ORIGINAL

DISTRICT OF COLUMBIA
STATE ADVISORY COMMITTEE TO THE
UNITED STATES COMMISSION ON CIVIL RIGHTS

Topic: AIDS Handicap Discrimination

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DCDC STATEMENT TO D.C. STATE ADVISORY COMMITTEE TO
THE UNITED STATES COMMISSION ON CIVIL RIGHTS
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REGINALD JENKINS M.D.

Chairman Washington and Committee members it is with great pleasure that I appear before you today to discuss correctional concerns with respect to AIDS. The D.C.Dept. of Corrections like many correctional facilities across the nation has had to meet the many challenges AIDS presents to every facet of government. In 1986 our department formulated its first Departmental Order on AIDS. This D.O. addresses two main areas of concern: Testing and Housing; and is consistent with AIDS policies of the majority of correctional facilities across the U.S. In addition education for residents and staff has become of paramount importance in stemming the rising tide of hysteria surrounding this disease.

Our policy on testing prohibits mass screening of inmates for the HIV virus. Testing is done within the established risk groups and at the discretion of the attending physician. This policy developed secondary to concerns with the difficulty of maintaining the confidentiality of test results in a small prison community as well as concerns with discrimination and other detrimental effects on individuals lives if results are divulged.

Our policy on housing states that asymptomatic seropositives will be housed in the general population. Symptomatic seropositives, i.e. those residents with ARC are house in the infirmary but are returned to the general population after their acute medical problem is corrected. Residents who meet the Centers for Disease Control definition of AIDS are housed in the locked ward at DCGH where they can receive the level of medical attention required. With the exception of AIDS patients at DCGH this policy protects residents from being identified as would occur if they were segregated. It also recognizes the fact that small correctional facilities are unable to adequately provide "separate but equal" programming for inmates who are identified as "having AIDS."

Many new problems have been presented since the original departmental order was written and the department is currently engaged in exchange with other governmental agencies to resolve them. The Department is committed to refinement of its policies on AIDS and will continue to address issues affecting our resident population.

C O N T E N T S

P R O C E E D I N G S

CHAIRMAN WASHINGTON: We are going to have the presentation of Congressman Dannemeyer, and we will allow a period for questioning immediately thereafter so that he may return to his duties, probably a vote, at 12:00 or thereabouts. We are pleased that he has volunteered to be a part of this forum and to leave the Congress at this crucial time.

I want to say that he is a national spokesman on the subject, and we are more than pleased to have him. I now present to you Congressman William E. Dannemeyer from the 39th District of California who will now address you.

PRESENTATION OF CONGRESSMAN WILLIAM E. DANNEMEYER:

CONGRESSMAN DANNEMEYER: Thank you, Mr. Chairman. I am pleased to have this opportunity of being here this morning and sharing my thoughts with this group of distinguished members of this Commission.

As a beginning point, I suppose we can start with what Congress adopted back in 1973, when it adopted the Rehabilitation Act (that year) which described discrimination against handicapped individuals. What Congress has meant by the term "handicapped individuals" has been an interesting exercise in the process of the courts and Congress itself since that term

was added to the law in 1973.

It was an Attorney General's opinion, under the Carter Administration, that advised that the definition of "handicapped person," as used by the Act of Congress, included drug addicts and alcoholics. Congress, in 1978, was concerned about that opinion and, by a subsequent act, made clear that the term "handicapped person" did not include a drug addict or an alcoholic.

That was the status of the law until the case that the U.S. Supreme Court recently handed down in which Mrs. Arline was the plaintiff. [cite] The Supreme Court of the United States, interpreting the same term "handicapped individual" concluded that it was the intention of Congress to include a person with a communicable disease as being under the definition of a handicapped person.

In that instance, the plaintiff had tuberculosis and alleged the protection of the law proscribing certain (non)discrimination against persons who are handicapped(, in that instance a person with a communicable disease,, in that instance tuberculosis.)

The Court reversed the matter to the trial court to determine(, in effect)whether or not(, considering all of the

factors that Mrs. Arline was otherwise included under the definition of "handicapped person."

As a member of Congress, I disagree with the Court's interpretation that the definition of "handicapped person" includes a person with a communicable disease. I don't believe that was ever the intent of Congress. One of the reasons I make that observation is that action that Congress took with respect to clarifying the law and the meaning of that term by saying expressly that it did not include a drug addict or an alcoholic.

If Congress could get to the point where it could vote on that issue, I think it would reach the same conclusion that it did not intend to include a person who had a communicable disease, because if we do conclude that the term "handicapped individual" includes a person with a communicable disease, we are at cross-purposes with ourselves.

For example, under Federal immigration law today, a person with certain designated infectious diseases cannot be admitted into the country. Among them are such curable communicable venereal diseases such as syphilis or gonorrhea, leprosy, active tuberculosis, chancroid, venereum, granuloma, or lymphogranuloma. If you have any of those, you can't come in the United States, under the immigration law.

Now get the paradox. If you cannot come into the United States when you have one of those communicable diseases, and yet we interpret the term "handicapped individual" to include within its ambit a person with a communicable disease. On the one hand, the Federal Government is saying, "You can't come in here if you have a communicable disease." On the other hand, we're going to say that you're going to be the benefit of a law protecting handicapped individuals if you do have a communicable disease.

The thing even gets to absurd implications when we address the question of Affirmative Action. Is our law in the posture today where an employer, having a contract with the Federal Government, under Affirmative Action, is to go out into the prospective work force and find people with communicable disease to be in their work force in order to satisfy the requirements of Affirmative Action?

I am not sure whether the Supreme Court even contemplated that absurdity when it rendered the decision that it did. I am not sure any of us know what the answer to that question is, but I have stated these reason for those among my conclusion that I do not believe it was the intention of Congress to include a person with a communicable disease under

the definition of a handicapped individual.

Some persons today in America today claim the Arline decision has applicability to the AIDS epidemic in America. I'm not sure that it does because, take the three stages of that disease: those with the virus who can be asymptomatic and those with ARC and those with full developed AIDS. If a person has a case of full developed AIDS, I think, clearly, they are handicapped, I think within the meaning of the law in the sense of satisfying the strict definition. They are sick, they are sick people, but because they are sick they are, nonetheless, qualified. So I don't think they can fit within the definition. That is a person with AIDS.

A person with the virus who is asymptomatic, that person is, in my judgment, because they are asymptomatic they are not suffering any impairment at all, physical or mental. They are not, therefore, fitting within the typical definition of "handicapped." Certainly, they are otherwise qualified because they are fully able to work.

So I don't believe that those with the virus for AIDS, or those with ARC, or those with AIDS are going to have any relief with respect to the Arline decision in terms of proscribing discrimination against persons who are handicapped

individuals, as that term is used by the Act of Congress in 1973.

Those are my comments, Mr. Chairman. I thank you very much.

CHAIRMAN WASHINGTON: Thank you, sir. We are certainly pleased, as I indicated, to have you here and express your views and to give some comments on the Congressional intent, particularly as it pertains to the handicapped.

Members of the panel, you may question or comment at this time, as you so desire.

MRS. GALIBER: Yes. I would like to ask the Congressman if you have with you your definition of what you consider to be a handicap.

CONGRESSMAN DANNEMEYER: The law says what a handicapped person is, within the meaning of the Act of 1973. There are, I think, five conditions: first, the individual must be handicapped, as defined in the Act. That means has a physical or mental impairment which substantially limits one or more major life activities, or has a history of such impairment, or is regarding as having such an impairment. That is a narrow definition of a handicapped person. That is the first criteria.

Secondly, the individual must be otherwise qualified;

in other words, notwithstanding having that handicap, they must be otherwise qualified to perform the job. Third, they must prove they have suffered discrimination by some as a result of having that handicap. They must show that their employer is getting Federal money, the Federal hook, so to speak.

The last condition is that notwithstanding that condition, the employer may not be put to an undue hardship as a result of accommodating placing that person so constituted in the work force.

That is the technical definition of the law; that is the definition that I would render. Whatever you define the law, sometimes it is easier to understand the law if you apply it to a certain factual situation, establish a factual situation for a person you have in mind and then see how the law applies. But that is the technical definition of the law. It is the definition that I presume in coming to the conclusion that I did.

MR. TOPPING: To just extend Mrs. Galiber's question, on the person with AIDS, as you view the law, is not in a protected class as a Commission on Civil Rights would be interested in?

CONGRESSMAN DANNEMEYER: I think a person with AIDS,

fully developed AIDS, under the narrow definition that our medical friends have established, that person is sick, very sick. They are handicapped within the meaning of the law because they are experiencing a physical or mental impairment which substantially limits one or more life activities. I don't question that, a person with AIDS.

I don't think such a person can satisfy another requirement of the law, in terms of the definition of a handicapped person because, in that status, I don't think they are otherwise qualified to perform the job because of their sickness. I don't know how a person, manifesting that degree of sickness, can possibly perform a job.

MR. TOPPING: But if that person could perform that job, whatever the qualifications of the job, then that person falls within the protected group or protected class by that public law in 1973?

CONGRESSMAN DANNEMEYER: I concede that, sir. If that person with AIDS could pass muster in terms of being otherwise qualified to perform that job, I think that he or she would be able to pass muster as fitting within the definition of that law. But, as I say, I don't concede the point that a person with a communicable disease fits within the definition of what

Congress intended to include within "handicapped individual."

MR. TOPPING: But not excluding AIDS, when a person is clearly sick?

CONGRESSMAN DANNEMEYER: I think the better way I would put it is, it was not the intention of Congress to include within the definition of "handicapped person" a person with a communicable disease, no matter of what variety.

In America, we report 58 communicable diseases -- in my State of California, we do anyway. I think most states are the same. Most of those are bad news for any of us. My point is, I don't think it was the intention of Congress to include any person with any of those 58 communicable diseases within the term of "handicapped individual."

MR. TOPPING: But, Congressman, I gather that there would be two aspects that would be critical to, let's say, a job-specific situation. One would be, presumably, the actual physical strength or physical capacity, let's say, of the individual to handle whatever the given job, to establish they are, otherwise, qualified there and, presumably, whether one were talking about AIDS, tuberculosis, or a variety of other diseases.

I gather the other consideration would be,

essentially, means of transmission of that particular communicable disease as that related to the particular job and, therefore, the likelihood and I gather, in those circumstances, the likelihood that somehow there would be transmission resulting there.

That ends up, to a degree, being kind of a factual determination that would, presumably, be job-specific as to what that would be, in some circumstances, with a given communicable disease, because let's say tuberculosis, in an active state, obviously that would be a problem. In the case of another disease, it may be that, in a given setting, if a person physically had the strength to be able to perform, that one may have a different balance. Would that be your conclusion?

CONGRESSMAN DANNEMEYER: I see what you are getting at, is that some diseases are transferable socially by, say, through the respiratory route, like tuberculosis. Other diseases are transferable, we believe, mainly -- like AIDS, for instance, through transfer of body fluids, drugs, blood or donation of blood. That is the main means of transmissibility. But we cannot rule out social transmissibility, the respiratory route. We cannot rule that out.

It is true that -- I am familiar with, maybe, half a

dozen cases in the medical literature where there has been casual transmission of the virus from one human to another, within family settings or in health care workers. About 3 percent of the total cases in America, CDC cannot tell us how the person got it. They just don't know. I see what you are getting at, but I will come back to it.

I never believed it was the intention of Congress to include, within the narrow purpose, the social purpose for which this law came into the books. Handicapped individuals, for employment purposes, essentially came in the law, in my judgment, to cover the situation where an individual, as a result of congenital, physical impairment, can function relatively well, notwithstanding, and can do a job. It is for that person that this law came into existence.

I hate to use the illustration of having acquired a condition as a result of an act of nature as opposed to a wilful act of an individual dissipating their human existence, because most of the cases of AIDS today in America is as a result of activities of humans, foolish and lax, over which they had control as to whether or not they wanted to pursue them, not all of them.

But 3 or 4 percent of the Americans today who have

the virus from blood transfusions, all they did in life was a need, depend on the blood supply, and they have the virus. They are probably going to die.

In other words, I am using that as an illustration. It was the Act of Congress, I think, to provide this protection, prohibit discrimination for those who were born with these defects, as distinguished from those as a result of activities in their life result in a manifestation of a communicable disease.

CHAIRMAN WASHINGTON: Congressman, do you believe that since 1973 and the advent or impact of AIDS upon our communities, that there might be need for updating the legislative intent and the nature of the protection, within the confines of this particular handicap?

CONGRESSMAN DANNEMEYER: It is always appropriate to do that, sir. It has been 15 years since Congress adopted this law and it has been 10 years since Congress said --

CHAIRMAN WASHINGTON: I was the Mayor back in that period, and I have seen the need for many things since then.

CONGRESSMAN DANNEMEYER: There is always a need to look at these things again, in the light of evolving conditions in our society. I would expect that sooner rather than later,

the Hundredth Congress will hold hearings on all aspects of this.

Unfortunately, sir, up to this time -- I am a senior member of the Health and Environment Subcommittee in the House, and the Chairman of that Subcommittee, Mr. Waxman of Los Angeles County, has seen fit to hold hearings only as a means of permitting witnesses who choose to teach or treat the issue as a civil rights issue. Mr. Waxman has not seen fit to hold hearings to permit witnesses who want to talk about the public health side of the issue.

Where this issue of a handicapped individual fits in that, I am not sure, but it should be -- Congress, as the institution in America that forms social policy, should be holding hearings and precising what this decision should be, rather than those nine unelected members of the U.S. Supreme Court setting social policy for all of us.

I mean no disrespect to any of them. Our system is better served when those people on that Court recognize they are there to interpret the law, in my judgement, in a rather narrow form, and not engage in social engineering. We are getting into political philosophy here, perhaps.

CHAIRMAN WASHINGTON: We're getting close to it, but

that's all right.

DR. COOKE: Obviously, Mr. Congressman, the legislative history of the House and the Senate Committees, back in 1972 and 1973, is not precise at all on whether the conclusion, even that you reach, that it was not the intent of Congress to include communicable diseases. Therefore, we conclude that the legislative history was vague 15 years ago.

CONGRESSMAN DANNEMEYER: Fifteen years ago, that is true; but 10 years ago, Congress took particular time to say, with precision, we would not include drug addicts and alcoholics within the Act.

MR. BINKLEY: Mr. Chairman, I would like to take a moment at this time to introduce the General Counsel for the Commission, Mr. William Howard, who has joined us and whom I invited to sit up here, but he is not sure how long he will be here. I think he has a question of the Congressman.

CHAIRMAN WASHINGTON: Yes. Mr. Counsel.

MR. HOWARD: I appreciate the invitation, but I don't see a chair.

I don't want to interject my questions until the members of the Advisory Committee have finished.

CHAIRMAN WASHINGTON: Laura, you have a question?

MS. CASTELLANOS: Outside of the Committee process itself, we all understand legislation, the topics we are discussing, the issues raised, not just for the Committee process, although that is the principal machinery by which, do you foresee -- and I know it is terribly riddled with pitfalls, trying to see what Congress will do -- legislation being introduced specifically to overturn the Arline decision, or Congress to limit that in some way.

CONGRESSMAN DANNEMEYER: I have done that. I have introduced legislation to do that.

MS. CASTELLANOS: Okay. And the bill number?

CONGRESSMAN DANNEMEYER: I don't think I have that here.

MS. CASTELLANOS: Perhaps we could request that of the staff.

What other legislative direction, besides your initiatives, Mr. Congressman, do you foresee? Have you approached Chairman Waxman on holding hearings on the public health issues, and just have not been able to go in that direction?

CONGRESSMAN DANNEMEYER: To answer your question, the earlier one, the bill that I introduced in the Ninety-Ninth

Congress was H.R. 5111, but of course that is history now. I introduced that on June 26th, 1986. I believe I have introduced that bill in the Hundredth Congress, but I am not sure, but in that Congress it was.

MS. CASTELLANOS: Thank you, sir.

CONGRESSMAN DANNEMEYER: On your second question, are you talking now or thinking now in terms of the AIDS issue, generally, or just this issue of handicapped individuals?

MS. CASTELLANOS: I will make it more of a general question, yes, sir.

CONGRESSMAN DANNEMEYER: I have introduced eight bills on the subject so far in the Hundredth Congress; six of them are gathering dust in the Subcommittee on Health and Environment on which I serve. Unfortunately, the issue is infested, to a very large degree, with politics and the current scene in America, which is a tragedy for all of us.

The political consideration is that the leaders of the Democratic Party in America have welcomed into their tent the activists in the male homosexual community who, to this day, insist on treating this epidemic in America as a civil rights issue as opposed to a public health issue.

I will share with you, candidly, it is a public health

problem of major dimensions, and there are certain steps we should be taking in America to deal with it. I speak of it in that way and I will continue to speak of it in that way.

But when you come to the fact and reality that 73 percent of the cases in America are comprised of one special interest group, male homosexuals, inevitably, when you talk about taking steps to deal with the epidemic, to control it, you come into contact with that group, which does comprise the largest group of AIDS cases in America and naturally, they say, "We should have a voice in that."

To the tragedy of the American people today, Mr. Waxman is carrying water, in the sense of the politics of the issue for those who want to treat it as a civil rights issue. To this date, he is ignoring those who want to treat it as a public health issue. That is a tragedy for all of us.

As a result of that intransigence on his part, I have introduced a discharge petition which will discharge the Subcommittee and Chairman, of which he is a part, to bring the matter to the floor of the House so that the American people will have an opportunity of having a debate on what we should be doing, as Americans, to control this epidemic.

There are certain fundamental, routine, customary,

normal responses that Public Health has traditionally pursued in controlling any communicable disease. The cornerstone, the basic tool, the building block of public health control is reportability, that those with the virus should be reported to Public Health authorities. The tragedy of the matter is, except for eight states in the Union, it is not being done today.

It should be done in confidence. It is nobody else's business. That system of confidentiality has worked very well where it has been practiced for decades in America in controlling communicable disease.

Candidly, because we have not, as a people, been pursuing, routinely, these steps, it is now a major political issue in America, and it will be a major political issue in the Presidential election next year because the American people are growingly upset about the failure of leadership on the part of Public Health officials in this country to take normal steps to control the transmissibility of this virus. That is where it is at.

CHAIRMAN WASHINGTON: Very well. Do any other members have a question or comment at this time? Counsel?

MR. HOWARD: Thank you.

If I could pick up just where you left off,

Congressman Dannemeyer, with respect to the Public Health officials. It seems to me that the threshold issue here in the discussion of civil rights and the public health issue concerns the transmissibility of the AIDS virus.

We have heard a great deal in the past few years from our Public Health officials. I wondered to what extent you think we are getting accurate information from our officials?

CONGRESSMAN DANNEMEYER: From the Public Health officials?

MR. HOWARD: Yes.

CONGRESSMAN DANNEMEYER: I think they have been a little disingenuous with the American people. The reason I say that is that, historically, in controlling communicable disease, we have pursued the policy of separating those with the disease from those who don't have it. Historically, we have done that.

In the instance with AIDS, we have just turned the system around 180 degrees. Our Public Health officials at the national level -- I am talking about CDC, U.S. Public Health Service, have essentially being saying to the American public, "Be quiet, don't panic. We will permit anyone with the virus, with the disease, to be in our society until it is proven conclusively that it can't be transmitted."

That is a major policy change in Public Health activity in America. As a result, candidly, there are a lot of Americans at increased risk of getting the virus who, otherwise, wouldn't be there.

There is little doubt in my mind, sir, that if the group that contributed 73 percent of the AIDS cases had gray eyes, a highly disorganized group of American people, politically speaking, I would suspect that a lot of Public Health officials in America would have quarantined that group two or three years ago.

But because 73 percent of the cases in America come from one highly organized, militant, activist group, male homosexuals in America, they have collectively, because of their clout, intimidated the actions of Public Health officials, to the detriment of the American people.

If you think about it for a moment, three cities in America have 52 percent of the cases: New York, Los Angeles and San Francisco. You can't get elected in those three cities unless, essentially, you have made your peace with the male homosexual activists residing there, and the Public Health officials that work in those cities reflect that bias.

When you look at where the leadership on the side of

those treating this issue as a civil rights issue has come in America, they have come from those three cities. They have had a powerful influence, to this date, on how this nation has responded to this epidemic, to the detriment of all of us.

It is a tragedy and we are, today, proceeding on the basis that it is better that a number of us die than for historians to record that we have infringed on the civil rights of some who are inflicted with this tragic disease. That is where it is at.

MR. HOWARD: It is my understanding that the category that you alluded to, of 3 percent of the cases, the origin of which cannot be determined by CDC, is, in fact, growing, that the percentage is upwards of 6 percent or 7 percent now. It all points to developing information. Would you care to comment on that?

CONGRESSMAN DANNEMEYER: The figure, the percentage of unclassified persons -- today the total of AIDS cases is around 40,000, and 3 percent would be about 1,200. I have seen figures as high as 4 percent on the unclassified cases.

CDC says that, well, we're not sure about -- I don't know how many of you are familiar with the history that is recorded when anyone has a communicable disease. They take

detailed information, and the CDC spokesmen sometimes say, "That of those that are in the class that we cannot classify, that we suspect they are not levelling with us. We suspect they fit into one of the high risk groups and they are lying to us about that." But who knows about that? Nobody knows for sure.

MR. HOWARD: You mentioned that 10 years ago Congress amended the Rehabilitation Act to exclude drug addicts and alcoholics, and that this was evidence of a Congressional intent not to include communicable diseases.

Could you discuss that at length? I don't see the link between alcoholism and drug addiction and communicable diseases.

CONGRESSMAN DANNEMEYER: Well, I think it has relevance in this way. If Congress amended the law where the definition of a handicapped individual, within the meaning of the Rehabilitation Act, so as to make clear that drug addicts and alcoholics do not fit within the definition of that protection, I would argue that it is logical to conclude that Congress also did not intend to include them in the definition of a person who has a communicable disease, no matter how they got it.

Most of us get communicable disease, even though we

are living the life where we think we shouldn't get it. We are all going to die one day, sooner or later, of something, and some of us will die of a communicable disease.

If Congress, as I say, said drug addicts and alcoholics don't fit within that definition, I think a person with a communicable disease also does not fit within the definition.

MR. HOWARD: Thank you.

CHAIRMAN WASHINGTON: Very well. Mr. Congressman, we appreciate very much your participation with us here today.

CONGRESSMAN DANNEMEYER: Mr. Chairman, a pleasure to be here.

CHAIRMAN WASHINGTON: We want you to know that you are free to join the members of Congress and to do the country's business in peace.

CONGRESSMAN DANNEMEYER: That is a polite way of saying, "Get out of here." Thank you very much, sir.

CHAIRMAN WASHINGTON: I didn't ask you if you had any material to leave with us, but if you do, we would be very happy to have it because we make it a part of our record. Thank you, sir, very much.

We will move right ahead, as our agenda indicates, and

will ask Attorney John Connelly of the Information, Advocacy and Protection Center for the Handicapped Individuals, if he will make his presentation.

As I indicated, we will go all the way through now, if you will, and have the presentations and the questions will come after each person has made their presentation, collectively. So the questions will not develop now until all three persons have had an opportunity to make their presentation. That will probably be the most orderly way, but we wanted to give the Congressman the courtesy of his time -- not that their time is more important, it is just that it is a courteous matter.

PRESENTATION OF JOHN CONNELLY, ATTORNEY:

MR. CONNELLY: Thank you, Chairman.

I am a little bit sad that the Congressman could not hang around a little bit longer.

CHAIRMAN WASHINGTON: I am, too.

MR. CONNELLY: I think you will experience a counterpoint point of view.

There are very few statements of the Congressman's that I agree with, and I think that my presentation reflects some of them. Possibly, also what you hear from my colleagues this morning, as well as from the District of Columbia

representatives this afternoon, will prove telling also with respect to the Congressman's remarks.

My name is John Connelly. I am the supervising attorney at the Information, Protection and Advocacy Center for Handicapped Individuals. My boss, the Executive Director of the Information Center, is sitting to your right, Mrs. Yetta Galiber.

The Information Center is a nonprofit, public interest, advocacy organization that has, for the past 17 years or so, represented the rights and rights to services of individuals with handicapping conditions.

We have operated on a number of different levels, not just legal and not even primarily legal, although I certainly have my hands full with court cases. We have 21 people and most of them are lay advocates. We have successfully protected the rights of individuals and their rights to services for a long time.

We are involved in the AIDS issue because of law, not politics. The law currently and, again, I will defer to my colleagues, both the Federal law and a majority of the Human Rights

statutes in various jurisdictions have positive AIDS as a

handicapping condition.

In fact, the Federal law is so broad that one need not be handicapped to be, in a sense, part of the protected class. The perception that one is handicapped is, in and of itself, enough to permit such an individual to be protected under the Federal Handicapped Discrimination Law. That is also true, by the way, of the D.C. Human Rights Act, the local Human Rights Statute.

The purpose of this meeting, as I understand it, is to look at the AIDS problem, especially as it affects or as it impinges upon the civil rights of those who are afflicted.

I want to spend just a little bit of time telling you some points about the condition. I am not a doctor, but I think it is important to keep these points in mind. I then would like to talk to you a little bit about the constitutional underpinnings that really died; a lot of the principles and court decisions and actions that control.

What you heard from the Congressman was merely an analysis of the Federal Statute, the Rehabilitation Act, which is but one chip in the game. There are constitutional protections under the First and Fifth and Fourteenth Amendment that directly bear on AIDS in particular situations. I will

discuss just a few of those situations for illustrative purposes. Finally, I just want to end with a comment on some of the Congressman's points.

First of all, though, AIDS is a disease. It is a deficiency of the human immune system. It caused by a virus which depresses that immune system and permits individuals who are afflicted to catch infections and diseases that they would not, otherwise, catch. So, for example, the common cold to an AIDS sufferer becomes a potentially lethal event. There is no cure for AIDS.

Not everyone who has the AIDS virus, as established through the current testing mechanisms that exist, will get AIDS, and that is a very important point. I will speak a little bit more about that later.

There is a very important distinction to be kept in mind between three categories of individuals, those with AIDS. Now, the Center for Disease Control in Atlanta defines AIDS as the opportunistic disease that one catches by virtue of having a depressed immune system.

There is a second category, AIDS-Related Complex, those individuals with ARC. These are a group, defined by individuals who have some signs and symptoms but not a full-

blown opportunistic disease. Finally, there is the group that tests sero-positive, those who test positive on the antibody test.

One word about the test, or the tests; primarily, there are two of them, the Eliza Test and the Western Block Test. These tests were originally designed to screen blood back in the late Seventies. They do not test for AIDS; they test for the presence of antibodies that the immune system develops as a response to the AIDS virus. That is an important distinction to keep in mind.

AIDS is a contagious disease. I think the Congressman used the word "communicable." Once you draw the distinction that was drawn, at least in some of the briefs to the Arline case, between infectiousness and contagiousness -- it is a distinction that goes a little bit like this: If we're all in a room and someone coughs, I may, indeed, get the cold that he or she has. Infection contemplates ready communicability.

AIDS is not -- the only good thing about it is that it is not casually transmitted. The scientific evidences does not -- or does establish that there is not casual transmission. One gets AIDS when one mixes infected blood with blood, when vaginal secretions or semen enter the blood stream of an individual.

Therefore, high risk activities, such as sexual relations, such as use of contaminated needles, such as transfusion of infected blood, are the, statistically, overwhelming and total three causes of the condition. To argue that some causes, the etiology of some conditions remain unknown is not to suggest that there is casual transmission. The logic just simply does not hold there.

AIDS is, finally, a health problem, a public health problem. Why? Because there is no cure for it. I mean it is virtually a death sentence at this point. It is also a problem not merely for a select group of individuals. For the District of Columbia, for example, it is an extreme problem for intravenous drug abusers, which we have a very large number.

There is an expandible increase in incidence of AIDS. The paper, my remarks that I have submitted in advance, indicate that current thinking is that one to 1.5 million people in the United States would test positive if they were tested. Finally, AIDS is a handicapping condition, and that is what the Supreme Court said int he Arline Case and what the state Human Rights Statutes have been saying prior to that.

I will not address discrimination, statutory discrimination, because I think it is going to be the thrust of

what a lot of what we will be talking about, both in the morning and the afternoon. Let me just share three particular areas: institutions, mandatory testing and the issue of segregation or quarantine.

Institutions, the problem that exists in institutions; we deal a lot with mental retardation and mental health facilities. The typical example of the institution might be the prison system. There, you have a captive population, truly. There, you have the rather free exchange of urine, blood and feces, and you have fights and you have sexual interactions, a ripe environment for, one would think, for the Government having some legitimate interest in effecting individual civil rights, privacy, confidentiality.

The issue in these cases is, admittedly, a tough one, and another issue there, of course, would be mandatory testing. The situations are complicated and there are certainly views on both sides.

The District of Columbia should be commended for having a very progressive policy with regard to the D.C. prison population. This is a policy which is in your packets, and promotes education, promotes the development of capabilities, to take care of individuals, persons with AIDS, which includes

those three groups, and also to promote the development of coherent policies.

Currently, my understanding of the system, the prison system in D.C., is that individuals who are tested and who do test positive are not at all segregated from the prison population. They are told of their positive test result and they are returned to the general prison population.

Those individuals who have AIDS-Related Complex, who have some sickness or some residual illness, are treated as other patients are and cared for, for that condition at the D.C. Infirmary, the Prison Infirmary. Finally, those with AIDS are actually put in a separate wing of D.C. General Hospital.

With respect to the issue of mandatory testing, which can certainly arise in the prison context. It is all over the papers. You probably know that there are currently proposed regulations for the testing of immigrants to this country, which are in their proposed rule-making form. The testing issue is also a difficult issue. Let me make our position clear. We support voluntary testing, confidential testing and even, preferably, anonymous testing.

The idea of mandatory testing is not a good one, and I will give you several reasons for it. First of all, testing

will not halt the spread of this disease. Secondly, testing will probably drive underground those people who should be tested. Third, besides being counterproductive in that respect, testing costs a lot of money.

Various states, again, for the prison systems, established policies. I think there are about five states that actually established mandatory testing policies, and they discontinued those policies precisely because of the factors that I just mentioned: too expensive, what to do with the results, and not therapeutic.

So the testing issue has, at least with respect to that population, has resolved itself. Now, we have the spector of testing arising in other contexts, and I think that will become an increasing problem in the very, very near future.

Just briefly on the issue of compulsory reporting, which is to say reporting by physicians of medical knowledge about their patients. This has been around for a long time and affirmed by the Supreme Court as early as 1887. It is counter-balanced against, of course, the privacy and liberty interests that one has, in his reputation and honesty and integrity.

The difficulty with reporting, the down side of it, is that there is concern about the guarantees for unauthorized

disclosure, concern about the purposes for which the testing occurs, and whether that testing will be used -- whether the reporting will be used for purposes not associated with the epidemiology of the disease.

Just a work about segregation or quarantine, quarantine being, I guess, the extreme form of segregation. If this class of individuals is not a suspect class that deserves heightened scrutiny under the Equal Protection Clause of the United States Constitution, an issue not yet decided, I admit I will be very surprised.

I am sure you are familiar that such heightened scrutiny for a class such as race, such as national origin or alienage, demands that one look at how that class is treated by society, demands that how that class is -- how the characteristics of that class, your skin color, for example, affects your ability to sit in other portions of the bus than the back.

I am sure, as a constitutional issue, this will arise with respect to persons with AIDS. There are other problems, of course, that relate to that, and one heightened scrutiny is necessitated for analysis of whether or not a particular regulation should be constitutionally upheld. You have the

whole issue of narrowly tailoring the means to achieve the statutory purpose.

Should one segregate all gay men because they are potentially AIDS carriers? I think that is obviously over-inclusive and -- or all intravenous drug abusers? It would not pass constitutional muster, precisely because it is over-inclusive. It is also under-inclusive because not everyone who has AIDS or is a carrier is white or gay.

I want to just make some remarks, in rebuttal to the Congressman. I kind of wrote a lot and I will restrict myself.

CHAIRMAN WASHINGTON: Yes, please. We are running a little behind. You may wish to hold those until the question period, or if you can summarize them now, go right ahead.

MR. CONNELLY: If I could just be permitted to close with one remark. The evolution of the definition of "handicapped" is, of course, something that the courts are very concerned with. It is certainly the proper posture for legislators to protect the public but it is, ultimately, the task of the courts to determine whether or not legislators have performed correctly when individual rights are infringed.

The Congressman is wrong with respect to drug addicts and alcoholics and their coverage under the Rehabilitation Act.

The Congressman is wrong to think that certain handicaps, because they are deemed wilful and not natural cause, should be treated differently.

In 1985 -- this is from the Congressional Record -- the Congressman, who is acknowledged in a footnote to a Harvard Law Review article, as a leading proponent of AIDS-control legislation, stated on the House plan that God's plan for man was Adam and Eve, not Adam and Steve.

Well, the point is that Steve has just as much right to constitutional protections, regardless of his sexual preference, or the color of his eyes or anything else. That, really, is what the AIDS issue is all about.

The Arline case speaks in great detail about the legislative history and the stigma and prejudice and misinformation that too often accompanies handicapping conditions. It is precisely that that is really the issue in this AIDS crisis.

Thank you.

CHAIRMAN WASHINGTON: Thank you very much. I am sure that at some time or other we will be able to furnish the Congress with your comments through the transcript. Whether he orders it or not, we may see that he gets it. He probably won't

particularly care to receive it, but we will leave it to him.

We will move right ahead, and I want to say this now. One of the procedures in the question period, I would certainly entertain questions from each of the panelists to the other as a means of clarifying any points that they have. I am sorry I didn't really think of that earlier so that you might have had an opportunity to say something to the Congressman. But we will certainly broaden it to give you that opportunity.

We now have Bruce McDonald, Advisory Board Member, of AIDS Information and Education Speakers Bureau. I think there was a little misrepresentation of what he was representing, but we have clarified it through his letter. He will be speaking under the egress of the Information and Education Speakers Bureau and not the D.C. Bar.

PRESENTATION OF BRUCE McDONALD:

MR. McDONALD: Thank you, Mr. Chairman.

The Chairman is referring to the fact that I am a local attorney, a member of the Bar, and I organized a conference under the auspices of the D.C. Bar Labor Relations Section earlier this year having to do with AIDS. However, I am not a representative of the Bar. That is what I wanted to make clear today, that the Bar itself has no position on any issue

having to do with AIDS.

CHAIRMAN WASHINGTON: That is so only because it is an order of the Court, and does not take positions. It has nothing to do with your presentation. Now, go ahead.

MR. McDONALD: That is correct. In any event, I am going to skip over some of the remarks that I prepared to give on the issue of discrimination, since it ties in with the handicap question and it is being much discussed.

I would like to say that I think the debate now needs to move away from whether AIDS is a handicap. AIDS is a handicap. Those of us who are interested in changing the law may wish to have a debate about how to change it, but as the law exists right now, AIDS is a handicap. Even though the Supreme Court has left open the question of whether mere sero positivity is a handicap, I feel confident that the courts will decide that it is.

The question is not whether it is a handicap, but the question, is what does this mean for the handicapped person? How does this affect his rights? What it means is that the employer will have a burden to show that the handicapped person is not qualified for a position before rejecting him or, otherwise, taking adverse action.

As we have noted here, the law states that you not only have to be handicapped, but you also have to be otherwise qualified for the particular position, or you could be otherwise qualified, with reasonable accommodation from the employer.

For example, it has been decided by the courts that AIDS carriers are not qualified to serve in the Foreign Service in overseas posts or in the military. What other areas of employment will the courts decide are ones in which an AIDS carrier is not qualified, and what does it mean to be protected as a handicapped person if the employer can just turn around and say that you are not qualified.

Suppose you are a surgeon who is HIV-positive; in the regular course of your business, it may be common for you to cut yourself and bleed onto or into a patient. Does this mean that you are unqualified to practice surgery?

Consider the food service worker; there may be an ample amount of evidence that the virus cannot spread from a food service worker to a patron in a food establishment, but there are also statutes and regulations dealing with communicable diseases that govern practices in the food service industry. Is AIDS a communicable disease? Yes. Does a person's HIV status entitle him to protection as a handicapped

person if the same medical condition disqualifies him from employment by reason of another statute or regulation?

These are all issues that will be litigated and are coming up on the horizon. But one thing is clear: the fact that one may be considered a handicapped individual does not mean that he is immune from adverse employment decisions. It simply means that there is a burden on the employer to show that the person is not qualified for the particular employment because he represents a risk to the health and safety of others, or because of some other legitimate reason. The employer would then have the burden to show that these shortcomings cannot be rectified by some reasonable accommodation.

In other words, the fact that person is handicapped does not unalterably shift the balance of power from one party to the other. It simply means that the person is entitled to his day in court, and put an onus on the employer to come up with some reason.

I don't have a problem with that being a state of law. I think it is time that we move on to the other issues, which I tend to identify as confidentiality, insurance, occupational health and safety, and testing.

On confidentiality, I would just say that it goes

right along with the handicap discrimination question. There are a number of bills pending in Congress right now that aim to deal with these issues collectively.

The question is, to what extent does the need for confidentiality limit the goals that might otherwise be achieved by having the information concerning an individual's HIV status? For example, if a hospital is in possession of HIV information about this, the hospital has an obligation to confidentiality. But does this obligation extend so far as to prohibit the hospital from requiring the information in the first place?

What about the conflicting obligations that a doctor or hospital might have to disclose a patient's AIDS status to third persons known to be at risk? What about the patient, who is HIV-positive, and who exhibits an intention to continue having unprotected sexual relations with unsuspecting third persons? This is one of the legal questions that is at the forefront of internal debate at the Center for Disease Control right now.

Insurance. The question of insurance has to do with the bottom line, i.e., "Who is going to pay for AIDS?" So far, no state in the country has gone as far as the District of Columbia, which prohibits an insurance company from requiring an

individual to disclose his HIV status. As a result, many of the companies who were writing life insurance policies in the District have stopped doing so.

It seems to me that insurance companies, being in the business of risk, inherently, are basically unable to operate in a rational fashion if they are not permitted to inquire about a medical fact as important as an individual's HIV status. However, whether this means that there is a, quote, "market solution," unquote, to the problem of supplying health care to AIDS patients is an open question.

Occupational health and safety. One of the most difficult issues concerns the health and safety measures that may be necessary in certain occupational settings. In fact, there is a hearing taking place today in the House Government Operation Committee dealing with occupational health and safety standards in the hospitals. Some unions have petitioned OSHA for a rule-making, and there is a lot of discussion going on about this.

The primary guidelines in effect at this time, for both hospitals and the food service industry and in general, are those which were published by the Centers for Disease Control in November 1985, and eventually hospitals subsequently updated,

but there is a growing feeling that these guidelines are too relaxed.

Finally, is the issue of testing. When we use the term "mandatory testing," we tend to conjure up images of a government official coming to our front door and forcibly subjecting us to an antibody test.

Under the Fourth Amendment to the Constitution, however, which protects against unreasonable searches and seizures, the Government would have to have probable cause to suspect that we were guilty of a crime before doing this. Being sick or being infected with the virus is obviously not a crime. So I cannot see anything like this happening.

But what about testing in the military or the Foreign Service, which is already taking place? This is mandatory testing, as is the testing that is conducted by the Red Cross before it introduces blood into the nation's blood supplies. How about testing in prison or in the case of aliens seeking entry into the U.S.? These are all forms of mandatory testing which are either taking place or will soon be taking place.

So there is a semantical problem here, and I submit that if we stopped calling it "mandatory testing" and started calling it "free testing," a lot of people would think it was a

great idea and would come to get some of it.

The real issue is whether we should start routine testing for marriage license applicants, hospital admissions, persons seeking treatment at sexually transmitted disease clinics, and others.

Now, what is the value of having this information? There is no doubt in my mind that there is a very great value in having this information for a number of reasons. First, our information about the prevalence of HIV infection is extremely poor.

We have been hearing the figure of 1.5 million Americans since June 1986 at the Coolfont Planning Commission. We also hear that the prevalence of infection is continually increasing, even exponentially, although we don't know how fast. If the number of Americans infected doubles every 12 months, and it was 1.5 million in June 1986, does this mean that there are now 3 million presently infected? Even assuming 1.5 million infected, we are already looking at health care costs of $10 to $20 billion a year in the 1990's.

What if we are wrong about the numbers involved? Don't we need to know the size of the problem in order to have a realistic plan for coping with it? And what about the value of

epidemiologic data, in general? Isn't it helpful to know whether the city in which you are living has a significant prevalence of AIDS?

How important is it to know that the AIDS population in New York derives mainly from needle users as opposed to the AIDS population in San Francisco? What kinds of questions would we ask ourselves if testing revealed an unexpected outbreak of new cases in a suburb of Cleveland or a rural community in Kansas?

With limited dollars to spend on educational efforts, I think it is essential to target those areas in which the prevalence of HIV infection is the highest, and to aim those educational efforts at the relevant demographic group.

Finally, does anybody doubt that each individual has the obligation to know whether he or she carries the infection and to respond appropriately? I believe that the majority of Americans share this belief.

I also believe there are millions of Americans who would welcome the opportunity to take the antibody test but who are afraid to do so and/or lack the initiative to see a doctor for that exclusive purpose. Therefore, I think we should stop talking about mandatory testing and start talking about free

testing that is available and routine in as many situations as possible. In the final analysis, routine antibody testing is a profound and ultimate form of education itself. For one thing, it drives the point home.

In any event, these issues are all parts of a complex problem. The debate has tended to be dominated by a combination of Public Health experts and gay rights activists. Each of these groups has its institutional biases, as does any constituency. Gay rights representatives may fear discrimination on the basis of sexual orientation and may feel a need for confidentiality in AIDS-related information that is not shared by the majority of heterosexuals.

Public Health officials may disfavor a wider approach to antibody testing because of the immense burden that it will involve. I am talking about fiscal, bureaucratic and psychological burdens, to name a few. For this reason, there has tended to be a consensus at the Centers for Disease Control and in the Public Health profession that testing is generally a bad thing. This is a consensus that I don't believe is shared, or ought to be shared by the majority of Americans.

I will conclude with the observation that there are enormous political and institutional biases that are operating

in this area, and I think we ought to identify these problems and move the debate into the general public.

Thank you very much.

CHAIRMAN WASHINGTON: Thank you very much.

We now have our final speaker for this panel, and I am hopeful that we can move right ahead. I want to allow some period before the break for questions. We are running a little behind, so that if we may move right ahead, we will have that opportunity.

I would like to introduce Paul Cushing, Regional Director, Region Three, Office of Civil Rights, U.S. Department of Health and Human Services. Mr. Cushing.

PRESENTATION OF PAUL CUSHING:

MR. CUSHING: Thank you, Mr. Chairman.

I am Service and Regional Manager for the Department of Health and Human Services' Office for Civil Rights in Region Three. Our geographic jurisdiction includes five mid-Atlantic states, plus the District of Columbia. We are responsible for ensuring compliance with Federal Civil Rights Statutes by recipients who receive Federal dollars from the Department.

As an employee of Health and Human Services, I feel somewhat compelled to defend some of my co-workers in the

Centers for Disease Control and Public Health Service. AIDS is both a public health issue and civil rights issue.

I think some of the comments and the ideas of leading us to quarantining individuals has not been a traditional way of dealing with sexually transmitted diseases in the field of Public Health. I think we can reasonably classify AIDS and its transmissibility in that kind of category. Quarantining is not the way that we would approach it, either historically or currently, under current Public Health control practice.

Secondly, CDC will not come out tomorrow or next year and say to us, "Golly, folks, we were wrong. AIDS can be transmitted casually." There is just too much evidence up to this point to demonstrate that it has not been. There have been intensive studies done both in New York City and in San Francisco, in homes and in settings where people live who have AIDS, who share common utensils, toothbrushes, bathrooms, and there has been no evidence of transmission in that area.

People are looking for 100 percent certainty. No medical professional is going to stand up and give you that kind of certainty. But you have a far greater risk of death or injury to yourselves by getting into your cars this afternoon and driving yourselves home than you will ever have from getting

AIDS through casual transmission.

Let me address some of the civil rights aspects that Ed had asked me to speak to this afternoon.

There has been some question, which I think our previous speakers have pretty set on, that AIDS is a handicapping condition, that persons who have AIDS are covered by the Rehabilitation Act of 1973.

By a little bit of background, in March of 1986, the Department requested some guidance from the Department of Justice on whether AIDS was -- whether a person suffering from AIDS, which is a syndrome and not a disease unto itself, -- suffering from the debilitating effects of AIDS, were protected by the law.

Justice responded by saying that Section 504 would offer protections to persons suffering from the debilitating effects of the syndrome, but those who were contagious would not be afforded the same protection. The DOJ went on to state that individuals that individuals, out of fear of contagion, could discriminate against persons who are HIV-positive.

In essence, Section 504 would have no application where an individual is excluded from a program or an activity based on either a real or perceived ability of the individual to

spread contagion.

Now, in March of 1987, the Supreme Court, of course, ruled, in School Board of Nassau County versus Arline, that an individual with a physical impairment, resulting from a contagious disease or tuberculosis, may be considered handicapped under Section 504.

And while the Court noted specifically that it was not deciding the issue of a person carrying the HIV virus, I think some of the Court's statements in its ruling are illustrative. If I can quote. "Congress acknowledged that society's accumulated myths and fears disability and disease are as handicapping as are the physical limitations that flow from actual impairment. Few aspects of a handicap give rise to the same level of public fear and misapprehension as contagiousness.

"The Act is carefully structured to replace such reflective actions to actual or perceived handicaps to actions that are based on reason and medically sound judgments."

By excluding individuals who would be perceived as being contagious or a threat to others, as was suggested by the DOJ opinion, there would be no opportunity to have that individual's condition evaluated. Thus, the Court states, and I further quote, "They would be vulnerable to discrimination on

the basis of mythology," precisely the type of injury Congress sought to prevent.

The Arline opinion renders the DOJ memorandum at this point inoperable. It now becomes a major point of reference in discussing the civil rights protections that are afforded to persons with AIDS under Federal statutes. Of course, the implications of this ruling can be overwhelming for our individual department.

The Public Health projections of 1.5 million persons infected with the virus -- we are beginning to brace ourselves for what we expect to be dramatic increase in the number of complaints that are filed both by individuals and organizations. Already, the number of cases in our department, nationwide, right now is at 50. While most of these cases fall into the area of denial of services, we can reasonably expect that, over time, we will branch heavily into the area of employment.

In consideration of what are really life and death circumstances around some of these cases, the Director of our Agency, Audrey Morton, has ordered the staff to develop and implement an expedited complaint process that will reduce the administrative time that is involved in investigating these complaints. I expect that this process will be in place by

September 1st.

The Department, as a whole, is endeavoring to develop a comprehensive policy on AIDS that will incorporate all the aspects of our activities: education, prevention, treatment, research, and civil rights protection. There has been a variety of drafts that have been prepared by the Public Health Service, the Assistant Secretary for Health, that are circulating through the Department for comment at this time.

Presently, OCR is accepting and investigating complaints filed by persons or groups who believe they have been discriminated against because of AIDS. In addition, under certain circumstances, we will also investigate complaints where there is a denial of emergency treatment in hospital settings, under what are the Community Service Provisions in the Hillburton Act. These are found at 42 CFR, Section 124.

There is a couple of givens here. One, the hospital in question has to be a recipient of Hillburton funds and, secondly, the individual, in order to have standing in such a case, must be a resident or work in the service area of a hospital.

We have not yet assessed the Title 6 implications of the AIDS issue. Blooming large before us is the fact that while

blacks represent 12 percent of our nation's population, they account for 25 percent of individuals within the AIDS group.

One last note which I think I would like to present to the Commission as a challenge, if nothing else. The real cause of discrimination in the arena that we call AIDS is fear, and we have to begin to dispel that fear. We have to join with our co-workers in the public health field to educate the public about AIDS.

Education, as we all know, at the present time is the only weapon that we have to combat the disease. It is the only weapon that we have to combat the spread of discrimination. If we allow the misinformation and the rumors that persist about the syndrome, if we allow them to continue and spread throughout our communities, we are doing a great disservice to ourselves and a great disservice in an attempt to control this dreaded syndrome.

Thank you for your time.

CHAIRMAN WASHINGTON: Thank you very much, Mr. Cushing. I am sure the Commission will accept the challenge because education, as education is, in general, is always in great need. I find too many people now that are living with literacy as a point of view. It certainly has its carryover,

and its implications into this very difficult situation.

I would like now to give the panel, first, a brief opportunity to question the panel members. John, you have got your hand up.

MR. TOPPING: This is a factual question for any of the panel members who might be familiar with this. I think the witnesses here and I think Congressman Dannemeyer, as well, also referred essentially to three gradations of potential conditions.

One would be that of someone who has tested sero-positive for the virus. Another one would be someone having essentially, a kind of AIDS-related complex, and the third would be the actual AIDS itself.

Now, is there, in any of the work that CDC has done in trying to trace, both through sexual transmittability and also through drugs, through drug-related, and I presume also passage through the blood stream, has there been any ability to statistically establish where the actual transmission of AIDS has actually come?

Has it come primarily from people in the sero-positive category, or in the ARC category, or in the AIDS category? I mean where is the actual transmittability primarily within the

process? I have not seen that in a public discussion, and that is going to be an important factual situation, at least as far as Public Health, if not as far as the civil rights, human strategists who deal with this.

MR. McDONALD: Maybe I could just give the thought, that one thing that they have noticed that they so far, I don't think, have been able to explain is that intravenous drug users who contract the disease seem to exhibit a certain form of pneumonia whereas gay males who contract the disease seem to have a predilection towards kaposi sarcoma.

As far as whether a person who is sero-positive is more or less contagious than a person who has full-blown AIDS or ARC, I would think we would all be kind of shooting from the hip. The virus is contained in the T-4 lymphocyte, and a person with full-blown AIDS, he is pretty much out of those.

So you could actually make a very good argument that a person with full-blown AIDS is less contagious than a person who is merely sero-positive, although the person who is merely sero-positive but asymptomatic, the virus probably hasn't multiplied sufficiently to fell him. So it is possible that the person who is somewhere in between there, on kind of a Bell Curve, may be the most infectious. But, really, nobody knows.

MR. CUSHING: There are so many variables. If you had full-blown AIDS, you would get a negative blood test because your immune system is totally destroyed, and you are not going to pick up the antibodies.

I agree with Bruce, and I think if there was anyone here from CDC, they would also agree that the point in time where an individual, when a particular line from a sero-positive to going through ARC to AIDS, the point where they are most contagious would be very difficult to tell.

I think you even have to look at individuals, once they have tested sero-positive, what their extended life becomes. Some individuals die within six months; some individuals last five years. There are so many variables in each individual's physical makeup, how well they take care of themselves, so many factors, that it is very difficult to say where it happens.

There is also an element of the efficiency of the transfer. Certain types of intimate contact are more efficient than others, regardless of the person's ability to transmit the disease.

Needle-sticks, there have been a couple of studies done of health-care workers who have volunteered, and I think

the number is about 600 now through a CDC-sponsored study, to have been stuck with needles that contain the virus, or contained blood that is carrying the virus, and have not become infected. A figure of like one or two out of that 600 have been affected.

Where you get a needle-stick, if it goes into the top of the skin, the skin is a great protector of the body; where the individual who is a substance abuser goes into the vein. When you main-line it, you are getting right into the blood system. If you go into the top of the skin, it is not an efficient way to transmit the disease.

People who ingest it, if there is -- most likely, the hydrochloric acid in your stomach will kill it, if you don't have any other open sores within the tract or within your mouth. So there is a whole question of the efficiency of the transmission, which they just don't have a good handle on yet, aside from knowing that there are some ways that are more efficient than others.

CHAIRMAN WASHINGTON: All right. I am going to vary the program for just a moment. We have some citizens who have come and this will be the only opportunity for them to ask the panel a question. If they, indeed, have a question and they

have taken the interest to come out, we would like to provide an opportunity for them to ask. I notice that there is a period, 3:30 or sometime, but you guys will be gone by then and they might want to catch you before you leave.

So I am going to open up the meeting to any of you that have come, nonpanelists, to ask a question if you desire to do so. Please feel free to do so. These are meetings that normally take on sort of a rigid position with respect to Commissioners and those here on the panel, but we see some of you here that have come and if you have a question, go ahead and ask it. This is a matter that is too important to overlook you.

PARTICIPANT: I would like to ask you a question, if I might. I have been noticing more and more that AIDS is considered a lethal weapon. I would like to know what your comments are on that. Anyone.

MR. CONNELLY: There is an article that I am aware of, or a case, actually, in San Francisco, involving a charge, a criminal charge of assault with a deadly weapon by an individual who -- I guess he bit a policeman upon arrest and also screamed, "I have AIDS, you had better watch out." I think the charges were eventually dropped. Were they?

MR. McDONALD: There are many criminal charges pending in this area. If you know that you have an HIV infection and you have unprotected sex with a person that you don't disclose this to, the prevailing thought is that you are guilty of intent to murder. These things -- there are a number of prosecutions pending.

PARTICIPANT: So it actually can go to court for attempted murder. Thank you.

PARTICIPANT: To what extent does the Federal Government have an obligation to provide general safe working conditions?

CHAIRMAN WASHINGTON: Would you identify yourself, please, as you ask your question. Go right ahead.

MR. SHORT: Don Short from the Red Cross. But I am not asking for the Red Cross.

If a person has the syndrome, he does not necessarily have -- he can die from a common cold. Is there any obligation from the Federal Government, under OSHA or any other regulation, to provide a safe environment because this person has the ability to die from something that is that common?

MR. CUSHING: I am not well versed in OSHA regulations or the law. I think, from our own Department's position, the

Secretary has issued a letter to all employees stating that individuals who -- that the letter was issued from the standpoint, I guess, of the transmissibility of the disease in the work place, and you are addressing more the issue of the individual's protection; is that it?

MR. SHORT: Exactly. If you have the majority population employed who have AIDS, either the syndrome or full-blown AIDS, or whatever, which makes them vulnerable to anything that comes along, is there anything extraordinary responsibility of the Government to provide a safe environment for those people?

MR. CUSHING: I can't give you from an OSHA perspective; but from a 504 perspective, there would be a requirement to provide some accommodations so that the person could perform the essential functions of the job. Now, what that would constitute, I guess, would depend on the certain set of facts. The fact that the individual is just vulnerable to certain kinds of diseases is a -- I think you have to view that they have a responsibility to take care of themselves.

Conceivably, they could be working in a setting that could be as germ-free as possible, although that probably is somewhat unrealistic to achieve given the quality of the air in

Federal buildings. But from an OSHA standpoint, I cannot address that.

MR. SHORT: The reason I brought it up is this backlash from cases where there has been problems with asbestos, whatever. Could there be anything connected with the syndrome which could be brought up in discussions?

MR. McDONALD: The sword cuts two ways. For example, a person who has AIDS may be a threat in the work place to pregnant women or other people who have a low immune function because the person with AIDS or HIV infection may be shedding certain kinds of viruses like sitamagella (phonetic) virus which is harmful to certain individuals with a suppressed immune system. So that kind of phenomenon is typically referred to as secondary infection, and it can be a threat either to the AIDS patient or to others in the environment; how much of a threat, I just don't really know.

MR. SHORT: Could I ask another question? Locally, there was a controversy. A doctor claimed that the CDC, in its reporting, did not necessarily include the effects of oral medication as depressing the immune system. You were talking about IV drug users as a way of depressing the immune system and creating an opportunity for AIDS to enter the body. He

mentioned that perhaps oral medication, which may do the same thing, were not included in the reports. Do you recall that?

MR. CUSHING: I don't recall it, but I don't see how it could happen. In the intravenous drug user, what is happening is that you are sharing a needle and one person's blood is being passed on to another individual, then his infected blood is then introduced into another blood stream, and that is what causes the syndrome or the virus to take hold in the immune system and begin the process. For someone who would ingest a drug or a medication orally, I am somewhat confused by the statement.

MR. SHORT: Would it make you more vulnerable; that was his point.

MR. CUSHING: I don't know how it would make you more vulnerable in the sense of what ingesting -- what it would ordinarily make you to anyway.

MR. SHORT: He mentioned he is discounting the effects of sexual transmission as a way -- he feels that perhaps people with depressed immune systems are more vulnerable to sexual transmission as opposed to directly with the blood.

MR. CONNELLY: I would just add, and I am no expert on the innumerable studies that are being done around the country,

but there is the whole issue of cofactors and you might have a situation where an intravenous drug abuser might have, let's say, have poor nutrition, we know they are not eating properly. He might have an immune system that is more vulnerable.

Then you have the density question which Paul brought up earlier, it is those type of things, I think, that in an individual case would make the difference between getting infected or not.

MR. SHORT: My only question is that, you know, I think is somewhat like the Belgrade Mosquito case, some are going to start coming in out of left field.

CHAIRMAN WASHINGTON: Very well. Are there any other questions? Sir?

PARTICIPANT: If God is the beginning of wisdom, fear of AIDS is going to be the beginning of death. It feels like fear is the killer, it is my opinion, because I had a sixth-grade girl who came for tutoring with me and she was doing research on AIDS. I asked her, "Why are you interested in AIDS? You are only in sixth grade." She is panicked. Somebody told her that it is a deadly disease.

I want to bring to this Commission or to this panel that AIDS is not the only epidemic which was in this world.

There was cholera; where is it? There was plague; where is it? There was malaria; where is it?

In my own lifetime, in my own village in India, I have seen tens and hundreds, tens and twenties of people killed in one village because of cholera. I go there in 1985, there is no cholera.

What I am trying to say is, there is a hope that this will be eradicated. This is one of the timely diseases or timely epidemics which is sweeping the world. Maybe we can call it punishment of God, whatever we can say. It is just like any other epidemic.

But again, bringing the point of who causes it has created this fear, I think. If cholera was caused by bad water or insects, now diseases is between human beings. That may be the intensive fear that people are getting, because I am communicating with you, because I am intimately related with you, I am going to die.

I think that kind of fear must be taken out of children, first of all, and the adults. What are you really doing on it? What agency is really working on it, to really get this fear, which is really the reason of death. What I want to bring is, AIDS is one of the epidemics we feel is terminated; it

is not going to be perpetuated. It is not going to be perpetuated.

CHAIRMAN WASHINGTON: A lady back her had her hand up. Please go right ahead.

MS. LETIRY: My name is Kathy Letiry, and I do have the honor of being the Executive Director of the relatively newly formed AIDS Education Bureau, precisely for the main reason that education now is the only cure and stop of the spread of the disease AIDS.

There are several groups, such as this AIDS Education Bureau, working in different areas. This particular AIDS Education Bureau is directed primarily towards the adult heterosexual community, going on the premise that we no longer have high risk groups, but we have a high risk behavior, repeating that it is a human to human transmitted disease, and a basic blood to blood, basically by sexual contact, over which we humans have control.

One does not have to get the disease AIDS. You can take precautions or you can not have sex at all. One is responsible for one's own behavior and one's own effect with the disease. Education is that which you know how to handle it, what to do or, more yet, what not to do, and eliminate fear.

CHAIRMAN WASHINGTON: Thank you. We will conclude with Mrs. Galiber's comment.

MRS. GALIBER: I have been sitting here wanting to make a comment after Paul spoke, because he spoke about the great incidence of AIDS in the black community and other ethnic minority communities in this country.

My great concern is the misperception that this is a white male homosexual disease, and many of the clients that we know of just don't realize that this can happen to them in other ways. I want to know if the Office of Civil Rights or any other Government agencies are developing educational material that will, in fact, get another kind of message out to persons who are really the ones that are suffering right now, when you look at the data.

MR. CUSHING: I know the CDC is investigating getting materials printed that will be in other languages, bilingual. How far away they are from that yet, I do not know. They are also encouraging local health departments, particularly where there are large minority populations, to begin to get out to the minority communications, to get the information out to people through the public health workers. What you have had happen is that a lot of the educational efforts about AIDS has come out

through the gay community itself. They had the first start.

But the social structure of a gay community in large metropolitan areas is predominately white, so that even black gay men are not going to be going into the bars, the gay bars, of Philadelphia, Washington or New York, so that whatever instruction or whatever information and education is going out through that system is still not getting to the black population.

The gay community is taking on the responsibility to try to reach out to the black population among gay organizations throughout some of the large metropolitan areas. To get to the drug abusers, those who are substance abusers, at least at this point, they are trying to build on the Public Health system that is already out there and rely on our Public Health workers who are, I think, -- I forget what the figure is, but CDC has a number of people in these large areas who, along with their other functions, are tracking down communicable diseases, which they still do day to day, to begin to get into those communities and inform people about what the risks are, whatever their sexual practice is or how their substance abuse practice is.

CHAIRMAN WASHINGTON: We will have to conclude this morning's session now in order to be able to get back in tome to

resume a little late for the second session.

I would like to recess until 2:30. we will be running fifteen minutes late, but we are now 45 minutes late.

The subject, obviously, has been intense, and we do appreciate the panel members who have come from their respective duties to participate, and for those citizens who have come, I hope we have provided some opportunity for you to participate.

We will resume at 2:30 in this room, and take Forum Number Two.

(Whereupon, a luncheon recess was taken.)

AFTERNOON SESSION

CHAIRMAN WASHINGTON: The Committee will come to order, and we will proceed into the afternoon with Topic B, D.C. Governmental Responses to AIDS Handicapped Individuals.

We will call Mr. Marvin Hart, representing the Director of the D.C. Office of Human Rights, who will lead off the forum for this afternoon.

PRESENTATION OF MARVIN HART:

MR. HART: Thank you. Good afternoon, Chairperson Washington and distinguished members of the District of Columbia State Advisory Committee to the U.S. Commission on Civil Rights.

I am Marvin Hart, an attorney at the D.C. Office of Human Rights and Minority Business Opportunity Commission. I am also a member of the D.C. Commission on Public Health AIDS Advisory Committee, Office Liaison to the District of Columbia Interagency Task Force on AIDS, a member of the Commission on Public Health AIDS Educators Committee, a member of the Family Services Subcommittee on Pediatric AIDS, and our office's AIDS Coordinator.

I am here today representing Maudine Cooper, the Director of the Office of Human Rights and Minority Business Opportunity Commission. I wish to thank you, Mr. Chairman, and

this Committee for the opportunity to appear before you to address AIDS handicap protections.

First, let me say that our office is pleased to be able to share with you the efforts we have made to date to address the needs of the District constituency as regards AIDS handicap protection. I will briefly outline our office's work interests and policies in this area.

In 1983 we received a telephone call from a young woman who did not wish to file a complaint but felt that our office should be aware that a new condition existed in the medical community which might give rise to discrimination.

As you know, though the virus which caused Acquired Immune Deficiency Syndrome had been isolated in 1981, very little was known or could have been predicted about the impact that AIDS would have on various aspects of our society, and particularly about how it would impact on opportunities in employment, housing, education and other community services.

Our office began to monitor the development of both the medical and legal information concerning AIDS after that telephone inquiry. The development of legal information was very slow and there was really no place to turn for specific guidance. The medical community had, however, defined AIDS as a

bodily condition in which the immune system destroys itself through the virus' reproductive process.

We reviewed the Handicap Provisions of the Human Rights Act of 1977, in light of the medical information available, to determine how we should process a complaint that raised AIDS as an issue. Upon review, we noted that in the a physical handicap is defined as a "bodily or mentally disablement which may be a result of injury, illness or congenital condition for which reasonable accommodation can be made."

We determined, in 1984, after a review of comparable legislation on both the Federal and state levels, that AIDS should be a protected illness, requiring accommodation. Our office received numerous inquiries throughout 1984, 1985 and 1986, primarily from lawyers, employers and concerned citizens groups regarding what our policy would be concerning AIDS. We informed each inquirer equally that our policy would be that AIDS is a physical handicap under the Human Rights Act, and that we were continuing to monitor the activity of the courts around the country for further direction.

As the number of inquiries increased, it became apparent that we would need to issue a formal policy statement

to ensure that employers, service providers and District residents would know their rights and obligations under the Human Rights Act.

Because we were drafting our employment guidelines through this same time, we seized the opportunity to further clarify the statutory definition of "physical handicap" by adopting, in part, the definition found in Regulations to the Federal Rehabilitation Act of 1973, which prohibits physical handicap discrimination by Federal contractors. We also specifically included Acquired Immune Syndrome in the list of conditions which could be considered physical handicaps for purposes of the Act. These regulations were formally published in August of 1986.

We then prepared our policy statement, our office's policy statement, and circulated it throughout the community for comments and recommendations. During this time, we were also working with the District Interagency Task Force to ensure that this policy would be considered and included in the city-wide plan.

In October 1986, our office co-sponsored a conference with the Interagency Task Force on AIDS, with the theme "AIDS, District Government and You," at which we formally outlined the

protections of the Human Rights Act provides for persons with AIDS. We mailed our employment guidelines to the top 200 employers in the District, and placed our AIDS brochures in various public locations.

We began to send speakers, on request, to various conferences on AIDS, and we incorporated a section on AIDS discrimination in our Equal Employment Opportunity Counselors Training Program.

Noteworthy is that during this period, the Supreme Court had agreed to hear the case School Board of Nassau County versus Arline to determine if a contagious disease, such as AIDS, but specifically in that case tuberculosis, could be considered a physical handicap for purposes of coverage under the Rehabilitation Act of 1973.

The Court did hold that a contagious disease may require the physical handicap protections of the Rehabilitation Act and, in so doing, set the tone for comparable interpretations for local statutes. We are pleased that the Supreme Court and our office were of the same mind on this definitional issue.

Currently, we continue to work with the Commission Public Health, specifically with the Office of AIDS Activities,

to help spread the word about the discrimination protections available for persons who have AIDS, AIDS-Related Complex, or persons perceived to have AIDS.

The protection of the Human Rights Act extends to persons who are unlawfully discriminated against because they test positive for the presence of Human Immuno-Deficiency Virus or because they are otherwise wrongfully perceived to have AIDS merely because they live, work or care for a person with AIDS.

This has been a brief and, we hope, informative look at what our office has done and is doing to spread the word about AIDS handicap protections in the District. I will now turn to a few specific areas of interest.

To date, our office has received five complaints, alleging discrimination on the basis of AIDS. We attribute this low number of cases to our early efforts to inform persons who inquired with us about our policy. In conversations with attorneys and employers, we found that once people became aware of our policies, they acted accordingly. This is not to say that discrimination is not occurring; it is to say that with the policy of nondiscrimination, it has been easier for the parties to settle their cases before formally filing a complaint.

When cases are filed, they are processed through an

accelerated case processing system. we bring the investigator in early and we begin processing immediately. We are constantly evaluating our system to make it as effective as possible.

Of the cases filed, four are currently under investigation and one resulted in a settlement. Because of the confidential nature of these complaints, we cannot reveal the specifics of the allegations. However, we can say that four of the cases are employment related and one is a public accommodations case.

Our experience has been that whites are more likely to file a complaint than nonwhites. We are working with the AIDS Educators Office to better assess the means of assisting nonwhite persons who have been discriminated against because of AIDS in utilizing available resources to seek redress.

Finally, we realize that AIDS will be providing us with new challenges over the next few years and, though our progress in both the medical and legal communities is moving slower than many of us would hope, we stand ready to meet those challenges.

I would like to thank you, Mr. Chairman and the Committee, for the opportunity to speak with you today. If you have any questions, I will be happy to entertain them at this

time.

CHAIRMAN WASHINGTON: Well, what our procedure is, we will go through the presenters and take the questions at the end, so that they have a comprehensive view.

MR. HART: Thank you, Mr. Chairman.

CHAIRMAN WASHINGTON: That will give the other participators a chance to get their material before the Committee before it interrogates them.

We have, representing Maurice Turner, the Chief of Metropolitan Police, Inspector Gary Abrecht. Inspector, you may proceed.

PRESENTATION OF INSPECTOR GARY ABRECHT:

INSPECTOR ABRECHT: Thank you, Mr. Chairman.

I am the Director of Planning for the Metropolitan Police Department and have been assigned by the Chief of Police to fulfill the function of AIDS Coordinator for the Department. Thank you for the opportunity to discuss our police department's response to the AIDS handicapped individuals.

Like most large police departments throughout the country, the Metropolitan Police Department has been dealing with the impact of AIDS on our operations for some time. The primary concern has been to protect our personnel from the

possibility of contracting the disease through contact with the blood or body fluids of infected individuals.

As we developed policy in this area, the overriding principle which Chief Turner enunciated was that we would not discriminate in providing police service to any person on account of their having this disease. This guiding principle grows out of the long history of this Department in the leader in the field of civil rights and community relations.

Sensitivity and responsiveness to community concerns have been important values to this agency for many years and, thus, it has been in that context that our policy has involved. We have been greatly helped in this regard by our active community relations effort with the city's large gay community over the last six years.

Starting in 1981, well ahead of practically any other department in the country, when Chief Turner first appointed a liaison to the gay community, our outreach efforts have continually expanded, so that we now have a captain in each of our seven police districts designated as a liaison with the gay community. In addition, a gay community representative sits on the Chief of Police's Advisory Council, and the Department actively recruits openly gay and lesbian person as officers.

This previously established reservoir of good will and trust proved to be very valuable to us when the fear of AIDS among our officers caused them to offend the organized gay community by wearing gloves and masks in two incidents involving gay persons. We were able to work, through our existing channels of communication, to assure the community of our continuing support and to obtain their cooperation in the preparation of a comprehensive policy on the wearing of protective equipment, which will be published very shortly.

The police department of this city will continue its long history of nondiscrimination and aggressive community relations under the challenge of responding to the needs of persons with AIDS. No one will be denied police service on account of their having AIDS.

When persons with AIDS come into our custody, they are treated and would be any other person with a serious illness. If they require medical care, it will be provided for them; if they don't, they are treated as any other arrestee.

I will be glad to amplify on any aspect of our policy that may be of interest to the Committee. That is the end of my prepared statement.

CHAIRMAN WASHINGTON: Very well. You're not using

gloves?

INSPECTOR ABRECHT: No, not any more.

CHAIRMAN WASHINGTON: All right. We will be happy to receive any of the panelists that may have prepared statements. We would appreciate it if you would leave them with Mr. Garden here so that they may be incorporated into the development of the material which will supplement the court reporter's reports as they are developed.

I would next like to call on Mr. Reginald Jenkins, representing Hallen H. Williams, Director of the D.C. Department of Corrections. He advises me that some 15 years ago I presented him with an award, and he looks so young I didn't know that I had presented it. He must have been in short pants then. He assures me that that isn't the case. I am pleased to have him here.

PRESENTATION OF DR. REGINALD JENKINS:

DR. JENKINS: I am Dr. Reginald Jenkins, the Chief Medical Officer for the Department of Corrections. Chairman Washington, Committee members, it is with great pleasure that I appear before you today to discuss correctional concerns with respect to AIDS.

The D.C. Department of Corrections, like many

correctional facilities across the nation, has had to meet the many challenges that AIDS presents to every facet of government. In 1986, our Department formulated its first Departmental Order on AIDS. This Departmental Order addresses two main areas of concern, testing and housing, and is consistent with AIDS policies of the majority of correctional facilities across the United States. In addition, education for residents and staff has become of paramount importance in stemming the rising tide of hysteria surrounding this disease.

Our policy on testing prohibits mass screening of inmates for the HIV virus. Testing is done within the established risk groups and at the discretion of the attending physician. This policy developed secondary to concerns with the difficulty of maintaining the confidentiality of test results in a small prison community, as well as concerns with discrimination and other detrimental effects on individuals' lives if results are divulged.

Our policy on housing states that asymptomatic sero-positives will be housed in the general population. Symptomatic sero-positives, that is those residents with AIDS-Related Complex, are housed in the infirmary where they can receive more intense medical attention, but are returned to the general

population after their acute medical problem is corrected.

Residents who meet the Centers for Disease Control definition of AIDS are housed in the locked ward of D.C. General Hospital where they can receive the level of medical attention required.

With the exception of AIDS patients at D.C. General Hospital, our policy protects residents from being identified as would occur if they would segregated. It also recognizes the fact that small correctional facilities are unable to adequately provide separate but equal programming for inmates who are identified as having AIDS.

Many new problems have been presented since the original Departmental Order was written, and the Department is currently engaged in exchange with other governmental agencies to resolve them. The Department is committed to refinement of its policies on AIDS, and will continue to address issues affecting our resident population.

CHAIRMAN WASHINGTON: Thank you, Mr. Jenkins. Many people have been interested in the activities of the Correction Department with respect to AIDS. I hope that if you have a paper there, you will leave it with the Committee.

We now have Dr. Reed Tuckson, the distinguished

Commissioner of D.C. Public Health Service, who is appearing for himself. He did not send a representative; he thought the subject was so important that he came personally from his heavy duties, and we certainly appreciate it.

Dr. Tuckson, you may proceed, sir.

PRESENTATION OF DR. REED TUCKSON:

DR. TUCKSON: Thank you, sir. I will be brief, but this is an important issue, I think, and it does demand my personal appearance here.

I am convinced that if we are ever able to get a handle on this epidemic, this unprecedented plague of ours in this community and around the country, one of the major aspects of it will hinge around how we solve, handle, debate and explore the problems of civil rights and human rights in those issues.

I think that, and I have said it on other occasions, but I think that this audience, in particular, it is important to stress that how this society is judged, ultimately, during this time, in this era of our development in history as a people, as a city, as a nation, will ultimately hinge on how we handle the issues of AIDS, because I think that there is no other issue, no other health issue, no other social issue that presents us more challenges in more areas of how we can conduct

ourselves as individual human beings, but also as social human beings, as political human beings, as an organized community of civilized persons.

So this issue, of course, I think most of us are very aware and have already started to analyze the -- and it shouldn't be a contradiction, but there is a contradiction between the treatment, and make sure we do all we can to treat an unprecedented disaster; on the other hand, making sure that we preserve and maintain all those things that this society holds dear and sacred, from a humane perspective.

So that, for me, ultimately becomes the most difficult part of my job as a Commissioner of Public Health, how to do all that we should do but not destroy the society in the process of doing it.

I am sure you have had presented to you, but let me just remind you that there are 744 persons in our city, in our city, in our one city that have come down with this disease, and over 60 percent of them are now dead, so that the numbers continue to grow. There is no slowing down of it. It still remains --

CHAIRMAN WASHINGTON: What were those figures again?

DR. TUCKSON: Seven hundred and forty-four of our

friends, neighbors and relatives have had this disease; 434 of them have died.

We are also aware, and it is a very important set of data, as we try to think through some of these issues as we go forward, is that a recent study of the military recruits in the District of Columbia suggested one out of one hundred of our military recruits, ages 18 to 30, from this city alone, are positive for the virus. That is not as frightening as New York and Manhattan and Brooklyn, where the numbers are like one to fifty, but still one out of one hundred says to us that this virus, unfortunately, is quite prevalent among our young people as well.

The issues for me are simple, and number one is the question of the most fundamental requirement we have is to educate, is to educate, educate, educate. Well, this is a pluralistic society that has many members of it from religious communities and have very strongly-held religious beliefs about the role of sex education to our young people.

While respecting that, I think my job, as a Commissioner of Health, is to advocate strongly that even down to the third or fourth grade level, we must talk to our young people with vigor and intensity about what this disease is and

how it is spread and transmitted. But that is something that a pluralistic society has to have as a course of its debate.

I think that in the course of education, we also have been confronted with the challenge of whether we talk about condoms in the public air space on the radio and television, an important debate to have. As a Commissioner of Health, my responsibility is to advocate that we demystify and de-energize the issue of condoms.

I think it ought to be a common a practice as we can possibly make it for those that are old enough and rational enough to make an intelligent decision to have sexual activity. I strongly do not suggest that young people have access to this. I strongly suggest that the message to young people is to abstain. But the point being that those that are adults ought to have access to condoms, and it ought not to be a mystical or difficult issue. Otherwise, we are headed down the road of disaster. But that is something that a pluralistic community must debate.

The second issue for us is the question of testing. Clearly, we need to know, from an epidemiological and scientific base, whether this disease is spreading, to what parts or subsegments of our community. While we understand this is not a

disease of high risk groups but a disease of high risk behavior, we understand that sero-prevalence testing is one good way of finding that out.

So we are prepared, and I think the prison system is one place where we will have to conduct well-designed, confidential sero-prevalence studies to see what the extent of the virus is, and we can do that. It does not require, I think, mandatory testing of the entire population of the city.

The question of testing, though, does get into the issue of whether or not we want to engage in mandatory testing and how we protecting the confidentiality of such. That is the central theme I wanted to spend my last few minutes on.

It is impossible for us to encourage the people who are engaged in the high risk behavior that we think would place them at most desire to come in for testing. It would be impossible for us to convince them to do so if it occurs in an arena of discrimination, in an arena of potential abuse.

A person who is known to be a drug abuser already is trying their very best to stay underground, and so he does not want to confront society in an organized way. A person who is a prostitute, -- a person who, in fact, is engaging in homosexual activity quite often -- or bisexual activity, quite often -- or

who is heterosexually promiscuous, quite often will not want to come forward for testing if they think, number one, that their life style will be exposed and, number two, if they think that if they have a positive test, they may lose their house, they will lose their job or their children will be denied access to the public schools.

For me, it is impossible, as a Public Health official, therefore, to have a testing program for those that really need it in the arena and in the perspective of the possibility of discrimination. So I think that this is as fundamental a part of my job as any that I can imagine.

We can convinced that at this point in time, given the state of the treatment art, that we ought to advocate for voluntary, anonymous testing for those individuals for whom it would be appropriate to have them.

I would end up, since I have used my five minutes, to suggest that no matter what the issue is, whether it is condoms given out in the prisons, whether it is how we decide to treat and deal with prostitutes, whether it is whether we do sex education in the schools, that it is very specific about AIDS. All of it ultimately concerns itself with how we, as a society, are going to organize ourselves and the kinds of messages and

signals that we are going to send.

I would hope and suggest that while this disease presents no black and white but only subtle shades of gray, that it is, in fact, of fundamental importance that the pluralistic debate be, number one, an informed debate but, number two, that it be a well-reasoned and a very active debate. Thank you.

CHAIRMAN WASHINGTON: Thank you, Dr. Tuckson. This was very illuminating. If you need another five minutes to complete your work, you can have it. I think you have given the Committee and the people assembled here a very good prospect, in terms of the education -- I remember one citizen who was right on target, apparently, with you. She was talking about education and training, and you glorify the two dimensions and initiatives.

But we do appreciate the words of all of the panelists that came, representing the various aspects of the District Government, and to know that the District Government is not only aware but is moving in a very positive way to develop a program that will treat, with the very difficult problems presented by AIDS.

We will now proceed in two forums. One, I want to give the Commissioners here an opportunity to raise questions

with the panel, and then we will open the floor for questions and comments from the audience, those people that are noncommissioners, I will say.

Ladies and gentlemen, we will proceed with questions and comments. John.

MR. TOPPING: I wanted to raise a rather general question. I will have to give some background, coming out of my other interests in civil rights.

The concern that I have always had and have here as this begins to develop is how the resources that will be designated for combatting this serious problem will and should be distributed, and what are the forces that determine distribution.

In the early stages of the civil rights movement, the initial movement, I was very much involved with it. Starting off, we've got to educate -- it was very general. We got to educate, we've got to educate, everybody has got to be educated. Then it began to narrow down. Then the question came, well, who is responsible? How do we get to focus the resources to get the biggest return for the buck and so forth.

That led, to shorten this, to such things as getting civil rights enforcement machinery. You, very aptly, put the

dilemma in this area of the public health aspect and the aspect of protecting and ensuring the civil rights of all citizens. We got to the place where we actually began to set up case files and to give money to send people out to see what was happening. Finally, we got to affirmative action, which gave some active rather than passive impetus from the managers, like yourselves.

As we look at this problem -- I thought I knew it, but when I began to read this information, to see the discrepancies and gaps, the difference, the disproportionality of the prevalence -- well, just the prevalence of the problem among different groups in the community, and then to get no indication of where the funds were going, except that we've got to have more funds, you've got to have a bigger budget; everybody has got to have a bigger budget, but no indication of where it is going.

Somebody else this morning mentioned the fact, quite parenthetically, that in developing educational materials now, it is greatly biased in the direction of a gay community problem, primarily because they were the most articulate in the early stages and the most affluent, and the most educated, so that you got tremendous amount of very good material on that part of the problem from a private source, whereas the later

statistics that we have, indicating the huge preponderance of this prevalence of this problem among minorities, among women, and you go down the usual line of victimization.

My question, just to close it up, with this in mind, could you give us any indication on how you see these developments and how you are going, in your program, to go from the general to the specifics?

DR. TUCKSON: First of all, I really appreciate the question because I wanted the time to explore this a little bit with you.

We are caught in a very difficult Catch-22 here. When we first noticed the beginning of this disease, persons from Haiti were singled out as being a major source of plague, almost, in this community, and there was a very real and very dangerous sort of discrimination against persons of Haitian descent, irrationally so and has proven, actually, to have been very incorrect.

I think that people of color are particularly concerned about being labeled as the cause of this disease, and people of color, we have noticed, have been very, very sensitive about some of these issues, especially as we understand that so much of the focus, from an epidemiological perspective and the

origins of this disease, seem to indicate some origins on the Continent of Africa, people of color have -- and with good reasons, for historical reasons, are particularly sensitive about being labeled in a negative way about this disease.

So we find that the black community, in particular, is very concerned -- has been, historically, somewhat concerned about addressing this issue and would, rather, prefer that it go away.

Also, we understand that the black community -- the perception when this disease was first noted was that because it was so overwhelmingly manifested in the homosexual and gay community, that it was not thought to be a problem -- this was thought to be a problem of gay white males, in particular, so that perhaps it did not involve the black community. Unfortunately, that reality, of course, is not the case, and that this disease is spread tantamount throughout our society.

What we are clear about, then, is that it has only been of recent note that the major leadership in the black community has focused in on the issue. We have not had, I think, in my opinion, until recently, the kind of demonstration by the major leadership in the black community about this disease. We have not focused in on it as an issue for the major

civil rights leadership in this country.

Now I am happy to say that it is, in fact, on the agenda of the NAACP and the Southern Christian Leadership Conference, and the National Urban Coalition, et cetera, and we are happy about that.

As regards how public funds are expended then, clearly, you are right, that the gay community was a much better organized political community, at least in this town, regarding this disease; certainly, were very thoughtful about their approach, and certainly willing to organize themselves into voluntary public/private partnership efforts. They raised a lot of money, were thoughtful about systems of care and how they could supplement what the government was doing.

It is clear that IV drug abusers are not well organized in the sense of being able to provide and advocate for their constituency. They may be well organized in terms of distribution systems for illegal contraband, but that is about as far as it goes.

Black clergy have seemed reluctant to speak about this issue from the pulpit and in the environment of the church. So some of the traditional institutions that are available to the black community have not come forward, heretofore, to organize

themselves.

The final answer to your question then, is, in terms of our education efforts, we are sophisticated enough to know, from a marketing perspective, that you market anything by understanding the importance of subsegments of markets. You do not speak to the Hispanic community and not understand the importance of the image of the macho male as a role model.

You do not market to the black community and have the same message that you would for the gay community, because we know that the black community is an overwhelmingly religious community and they don't want to hear certain things presented unless it is presented very, very carefully and in certain ways.

Our general education effort, given the demographics of D.C. being 75 percent black and minority, I think that the money that we spend for education for the city ultimately becomes, by definition, education to the black community. The gay community, I think, has done a fantastic job on its own and with the government's support. Our efforts are going to be targeted much more directly now towards the larger community, and being very specific.

We do not feel -- although I appreciate the role of advocacy, this government does not feel that it needs to be

reminded of the need to watch the distribution of money, and making sure that it goes to all the segments of the community that need it.

But it is just so very hard, when you realize that the numbers of people that are going to have this disease are people who are from the IV drug abuse community and the underground of our city, and it is hard to organize that system.

CHAIRMAN WASHINGTON: Let me ask you, Doctor, have you had occasion to make this speech in any of the churches?

DR. TUCKSON: I have been encouraged. We have spoken to, had the opportunity to address several hundred clergy.

CHAIRMAN WASHINGTON: Baptist churches and clergy?

DR. TUCKSON: Yes, and Baptist ministers. Not within the pulpit, but in the back room. I am encouraged by the response.

CHAIRMAN WASHINGTON: I mean on Sunday morning at 11:00 o'clock.

DR. TUCKSON: We are at the stage where the clergy have been spoken with, and are convinced of the need to have this happen. I have not personally spoken at 11:00 o'clock, but I do see that coming, and I do see that the ministers are feeling their responsibility now. I want to be very clear; I am

extremely encouraged by the responsiveness of the black church, in particular.

CHAIRMAN WASHINGTON: Jim.

MR. BANKS: Mr. Chairman, I have a question for three of the panelists, first to the Inspector.

Inspector, how does an officer determine, when he or she is making an arrest, whether the arrestee has AIDS?

INSPECTOR ABRECHT: Generally, the officer does not know, unless the person -- normally, how we come to know it is when an individual, for whatever reason, thinking perhaps that we would release the person or for whatever reason, tells the officer. That is about the only way that an officer tends to know.

MR. BANKS: In the incidents that occurred with regard to the use of gloves and masks, were those persons identified as AIDS victims before, before the arrests were made:

INSPECTOR ABRECHT: There really were two incidents, as you are probably aware. There was an incident where we were conducting a raid on an illegal after-hours ABC establishment, Alcoholic Beverage Control establishment, where there was no knowledge on the part of the officers involved that this was, that there were any AIDS patients there and they, essentially,

acted because they knew that the place was patronized primarily by members of the gay community.

The second incident, of course, was in front of the White House when a demonstration during the National Conference on AIDS at the Hilton, were we were told that some of the demonstrators, who were asking to be arrested, did have AIDS, not a large percentage of them, but some of them. We were not told which ones, so that was the dilemma that the officers felt that they were confronted with at that time.

MR. BANKS: Dr. Jenkins, you indicated that were three, I think, categories given to persons with AIDS in the Corrections Department, one for those who are identified as AIDS victims in the hospital, one for those who are suspected of having the virus, and one for those that obviously have the virus but have some illness that is treated in the infirmary.

DR. JENKINS: Yes.

MR. BANKS: You didn't indicate how many of your population fall within those categories. Is that information available?

DR. JENKINS: Well, the Department of Corrections has a total population of about 7,000 incarcerees. At present, we have two AIDS patients who are housed at D.C. General Hospital.

Since 1985, we have had a total, to date, of 12 deaths secondary to AIDS. We keep a running count on the number of people per year who are sero-positive, and for the current year, of about 100 people tested, approximately 48 of them are sero-positive, or are carrying the virus. To date, most of those people are healthy.

MR. BANKS: Forty-eight out of 7,000?

DR. JENKINS: Right. Of those who are tested, but our test procedure is that those in the risk group are tested, and those who are symptomatic take greater precedence over those who just want to be tested because they want to know whether or not they are sero-positive. If they are in a risk group, the medical officer has the discretion to test them.

MR. BANKS: How do you determine risk groups?

DR. JENKINS: If they give a history of IV drug abuse, homosexual activity or having been transfused, if they have a sexual contact who is known to be sero-positive or known to have AIDS.

MR. BANKS: Thank you very much.

Dr. Tuckson, my question to you is somewhat general. You made a strong point, that discrimination against a person with AIDS would deter persons, who had the possibility or had

symptoms, from identifying them or even taking tests because they would be fearful of being discriminated against.

In terms of public policy, a position against discrimination carries with it, I presume, either a medically defined limit or some information that is generally accepted in the medical community, that there are no dangers or few dangers to the general population in the normal contact between AIDS patients and that population. I mean housing, restaurants, all of the general facilities which are available to the total community and, therefore, discrimination is out of order, and the public is protected.

DR. JENKINS: Yes. Basic scientific evidence that underlies the answer to your question is that, again, this disease is transmitted only in very direct and extremely intimate ways. While this is a very lethal virus, it is one that you have to go out of your way to an extraordinary way to encounter. So a person who is positive for the virus or who has the frank disease is not a threat to their fellow human beings unless one is intimate with them.

The only caveat to that is a special kind of intimacy that comes with the work of persons who are in contact with blood and bodily fluid, such as our emergency ambulance workers

or, in some cases, the police department and, of course, hospital personnel. Even there, it is only if they are in extreme direct contact, have contact with the blood of that individual into a susceptible part of that worker. Thus, it is extraordinarily rare, almost, almost unheard of for a health care worker to be exposed to this virus in the course of what they do.

Therefore, the point is that -- you are right -- it is inappropriate to discriminate against a person with the virus, especially that, absolutely, and even with the disease, in the general population.

MR. BANKS: That, of course, means that the education challenge is more difficult, because if the disease is transmitted only through the most intimate contact, it is the description of the intimate contacts that those who deter from talking about it in public wish to avoid.

DR. JENKINS: Precisely one element of the dilemma. Our survival hinges on our ability not to be queasy about real life.

MR. BANKS: Thank you.

CHAIRMAN WASHINGTON: Commissioner Galiber.

MRS. GALIBER: Dr. Jenkins, I have been reading a

paper given by Mr. Williams, the head of the Department of Corrections, and he mentioned that at the D.C. Detention facility, that 375 tests were performed, and of that number 187 positive results. I am just wondering, since you have that captive audience, you have not done that at some of the other facilities if, indeed, your figures might be drastically off.

The other thing I wanted to ask you is, what is the position of the Department now, as it relates to what Dr. Tuckson said, in giving out condoms?

DR. JENKINS: That sounds like a loaded question. As for the first part, the total number of people tested in the Department since the test was licensed is, roughly three hundred and some people. We have that documented by records. I am not aware that 187 of those are positive; I am not sure.

CHAIRMAN WASHINGTON: She is reading it.

MRS. GALIBER: It is right here.

DR. JENKINS: The figures that I gave were the testing statistics for 1987. Those are probably cumulative numbers for the Department.

MRS. GALIBER: This is May 1987, Status of Prevention of Acquired Immune Deficiency Syndrome in the District of Columbia Department of Corrections.

DR. JENKINS: I will have to check the data.

MRS. GALIBER: But these are shocking statistics, right, if that is accurate?

CHAIRMAN WASHINGTON: Could they be cumulative?

DR. JENKINS: They are probably cumulative totals since 1985, when we started doing the testing. A lot of those people are not still in the system. The statistics that I am reporting are people that are still in the system, people that have not been paroled and are still in the custody of the Department of Corrections.

These are the statistics for Lorton; I haven't included statistics for the D.C. Detention Facility, which we are still gathering.

As for the question of condoms, that is a very controversial issue. What I would like to state is that the D.C. Department of Corrections is an institution and, as all institutions, we have rules for the safe operation of that institution.

One of the rules is that homosexual activity is prohibited, and we have sanctions for documented activity, as such. So it sort of puts us in a bind to, on the other hand, have rules and laws which state to a population that we are

trying to get to conform, to get back into the community, to, on the other hand, say, "Well, we know we have those laws and regulations that you are supposed to follow, but here are the condoms for you to use for whatever you are going to use them for."

CHAIRMAN WASHINGTON: though it be prohibited.

DR. JENKINS: Though it be prohibited.

I think, as a correctional facility, we have a problem with that aspect of it.

I can understand -- as a physician, I understand the need for condoms as a means of protection, but there are other ways that people can protect themselves. For instance, abstinence is one. One of the reasons why we are trying to educate the residents as to risks -- and you have to keep in mind that what places you at risk is behavior, and if you can modify the behavior, it lessens your risks. Condoms, I don't think is the total answer to the correctional part of that problem.

CHAIRMAN WASHINGTON: Yes, John.

MR. TOPPING: I have a question for both Dr. Jenkins and Commissioner Tuckson here.

First, has the D.C. Corrections Department ever

attempted, through any kind of a confidential survey or anything, to get any indication as to the percentage or the likelihood of involuntary sexual relations within the Corrections Department, and what is the actual instance -- is there any kind of handle?

Obviously, all of us here have seen various stories in the papers about situations that have happened. But the question is just how prevalent is this, and to what extent, if any, of these numbers are even remotely close to what you have been talking about here, roughly 50 percent of those tested, being exposed to the virus are, in fact, true; to what extent is there risk to the general prison population as a result, essentially, of involuntary sexual relations?

Do we have any kind of a handle on that? I mean is there one chance in two, in the course of a year, or one chance in a hundred that someone is likely to be subject to that?

DR. JENKINS: Well, from the medical aspect,t he reporting of sexual assaults is -- it is a tricky matter to document, because -- that goes for most assaults. Most assaults are reported by inmates as being a basketball injury, or "I fell down the steps," or something like that. A lot of them are probably under-reported.

We see very few documentable cases of rape, that we can document medically in the Department of Corrections. That doesn't say that it doesn't occur; it does occur. The point I am trying to make is that because of the nature of the correctional community, these things are usually not reported.

MR. TOPPING: Is there any way, short of reporting, to find out -- I mean focus group activity, or maybe it is people after they have been out -- I mean is there a way of getting any kind of a handle as to the severity of the problem?

DR. JENKINS: It has been very difficult. I have tried to survey some of the residents to see, to get a handle on how much homosexual activity there is. It is known that deprivation, homosexuality is a reality for the correctional system. Getting a handle on to what degree it is a part of the correctional system is difficult, because it is sort of an underground society. Number one, they are doing something illegal, and I am part of the official system, so it is going to be difficult for me to get that information.

We have had anecdotal-type data from people who have been in the correctional system, and their reports state that there is little to none, or you may run into someone who may say that it is rampant. So you really cannot get a reliable,

scientific type of evaluation of that type of activity.

We don't, that I know of -- we don't have a lot of sexual assaults that are documented medically.

MR. TOPPING: Thank you.

Commissioner Tuckson, I wondered, based on your assessment of the situation generally, in a circumstance involving one having the virus and others, to what extent is there, in fact, safe sex? I mean presumably using the condom, whether heterosexual or homosexual, in either case. But assuming the use there, do you have any kind of statistics over a period of time as to what the statistical effectiveness of, let's say, the proper use is likely to be?

I mean I assume particularly in the heterosexual situations where you might have two sex partners, one having the virus and one not, that there actually would be a chance to be able to observe the effectiveness over a period of time. Can we draw any conclusions from that?

DR. TUCKSON: Well, the best data is actual data involving members of the gay community. That data strongly suggests to us a couple of things; first, that the incidence of rectal gonorrhea has markedly decreased in the country. That tends to tell us that there is certainly some change in

behavior, in a very significant and meaningful way, in that community. So that is very helpful.

In terms of the heterosexual community, I don't have similar data. I have not seen any, at least in this city, good trends of sexually-transmitted disease yet. But we certainly would hope that we would start to see it. So I can't answer that question quite yet.

In public health, there has always been the issue of trying to equate knowledge and attitude with the change of behavior. It is very difficult to demonstrate. The bottom line for us, the score card is going to be simply the curve of the number of cases, and whether we can actually see the curve starting to change.

It still is true that the heterosexual community represent 1 percent of the number of cases in our community. I could put the adjective "only 1 percent," but still, that 1 percent is too much. I don't know if that is 1 percent going to 15 percent in the next two years; it is simply too early to tell.

The problem with all of this, and the science behind your question is that from the time of on-set of the virus until the diagnosis of the disease can be as long as five years. So

we are really playing with tips of icebergs here, and it is too early to tell. But at least the encouraging thing is, the good news out of all of it is that if the gay community can decrease their rate of rectal gonorrhea, then that tells us that people, with knowledge and incentive, will change their behavior.

CHAIRMAN WASHINGTON: Yes.

MS. CASTELLANOS: Does the Department of Corrections have a different policy for dealing with parolees that have tested sero-positive, whether it is symptomatic or asymptomatic?

DR. JENKINS: I am not sure exactly what you are looking for.

MS. CASTELLANOS: Is there a different policy for a parolee who has tested sero-positive in terms -- I understand you would offer assistance in terms of getting them employment as part of the parole process, and checking up to see if they are getting employment, house, education, if that has been started within the corrections facility, et cetera.

Obviously, someone who has tested positive is going to run into additional problems after leaving. Is there a special sort of policy to ease that transition?

DR. JENKINS: No, not to date. The original departmental policy -- we are in the process of revising our

Departmental Order. The original Departmental Order was presented in 1986, the early part of 1986, and it has not been changed since. It, for instance, doesn't include females who are detained at the detention facility. It does not include the parolees, to a great extent. It is a general type of policy which covers inmates in general, and mostly those who are held in confinement.

The health care of residents who are in Half-Way Houses is the -- they are taken care of by D.C. General Hospital, mostly. They report to the public system, as would any other person. But as far as developing special procedures for finding them employment, that kind of thing, there is no policy.

MS. CASTELLANOS: You are saying that it wouldn't be so much the policy of the Corrections Department to develop it, but the Public Health Service, at that point?

DR. JENKINS: I am saying -- we are looking at some of the problems that are coming up with parolees. For instance, there are problems with some of our sero-positives getting into drug treatment programs, because they are sero-positive. Part of the condition for them to apply for these programs is that they have to be sero-negative or they don't qualify. So that is

one of the problems that we are running into. We're looking at that, and we are going to change some of our policies, accordingly, when we redo the Departmental Order on AIDS.

I would just like to comment on the numbers. These are cumulative. These are cumulative, that 375 with 187 positives, are cumulative numbers since we started testing, and that is both at Lorton and at D.C. Detention Facility.

MRS. GALIBER: I want ask you this, based on your belief that you won't be able to give out condoms; are you all providing some kind of on-going educational services to the residents to prevent some of these things?

DR. JENKINS: The idea of education has become of paramount importance, especially for the Department of Corrections. As I stated before, behavior plays a great role in disease transmission here. What we need to do is educate residents as to how this disease is spread, and how modifying their behavior can decrease their risks.

We also are concerned with staff, because staff react to -- sometimes in a discriminatory manner -- to residents that are identified as sero-positive. For a small correctional system, keeping the sero data about someone confidential is sometimes difficult.

CHAIRMAN WASHINGTON: Has anyone, Doctor, made any effort to relate overcrowding to the problem of this or any other disease factor? It just occurred to me, as you were talking, that that is your big problem.

DR. JENKINS: Well, overcrowding is going to tax all of the systems, including the medical system, including the medical surveillance. So my answer to that would be yes, it does impact on this disease as well.

CHAIRMAN WASHINGTON: We have arrived at the point where we would be very happy to entertain questions or comments from those that are noncommissioners here, who might wish to comment or raise a question.

MR. BINKLEY: Do I call in that category, Mr. Chairman.

CHAIRMAN WASHINGTON: If you put yourself in that category.

MR. BINKLEY: I would like to ask these two gentlemen, all of you seem to represent agencies or organizations that have given you support for the job you have to do in connection with AIDS.

I wonder if, within your experience, you could share with us, if you had the authority to do so and more money, what

would you do to improve or change what you are presently doing, if anything. Any of you. Mr. Hart.

MR. HART: What I would do is what we have all been talking about, is educate. Spend the money on finding whatever mechanisms to reach the specific cultural groups which we are missing currently. I would focus the funding on that, education, because it is the education that will lead to a change of behavior, and that is the primary behavior -- the behavior as opposed to the groups.

Unfortunately, in the beginning, we were focusing on this group and that group and the other group, and that has placed, I think, a primary barrier to our education, because now we have got to educate people beyond the group thinking to behavior thinking, and then we have got to educate them further on trying to change that behavior. So that is the focus that I would take.

CHAIRMAN WASHINGTON: I take it that is something that all three of you would relate to, education and training. If you had more money, more resources, you would have more education, more people, more trained people to deal with the problem.

INSPECTOR ABRECHT: Certainly, education is very

important in the police department. Part of the problem that we do have is officers who have great fear of the possibility of contracting this disease from the many kinds of often difficult people that we deal with, and the officers are very fearful of that, and legitimately so.

I think providing them with good education, which the Commission of Public Health has been doing for us, but they have a very small staff and they are not able to do it as much as we would like or they would like. Providing good education to our officers is certainly a very important part of this, and that would be one thing we would have to spend money on.

The other thing, of course, would be protective equipment for the officers when they do encounter blood or body fluids at the scenes of accidents and things of that nature. The Chief has made money available for that, so we really don't need any additional funds for that, to my knowledge.

DR. JENKINS: For the Department of Corrections, we have been, in the medical field, doing our own AIDS education initially, and the need to have an expanded educational program, involving government contractees, for instance COBA Associates, and through the Aorta Project Whitney Walker Clinic became important.

They have been giving seminars to the residents and have conducted AIDS training courses with our staff members. I cannot stress enough the importance of educating both residents and staff about this disease, so that there is more rational thinking about it and less hysteria.

MRS. GALIBER: Is that training going on behind the walls, too?

DR. JENKINS: Yes, it is. And we are presently moving to augment that program, because we want to get the message out to everyone.

CHAIRMAN WASHINGTON: I am sorry that Dr. Tuckson isn't here for further questions, but he apparently is attending a person that has had a sun stroke or a seizure or something. I suspect he is waiting for the ambulance.

In the meantime, you have three members of the panel; if there are any questions that anyone would like to address to them -- yes.

MR. CONNELLY: Just to supplement what was said before relating to the incidence of the occurrence of AIDS in hospitals. Further complicating the fact, besides of course the under-reporting and the fact that it is illegal behavior, is that prisoners come and go. There is no real handle on to what

extent, within prison walls, AIDS is spread.

There is one study that I know of, and only one, that was done by Maryland, involving 137 long-term inmates, longer term than the AIDS crisis has been. I believe out of the 137 individuals, under 10 became sero-positive which is, admittedly, a small population but, nevertheless, is a disturbing result.

My question, to return to condoms; as you probably know, Dr. Jenkins, the City of New York and the State of Vermont have policies supporting the dissemination of condoms in prisons. The City of New York makes the condom available to, I guess, individuals in high risk groups who seek it or are advised to use it, through the medical counseling process.

I am wondering if that type of mechanism, that instituted by the City of New York, for individuals in high risk groups who asked or were given the option might be the way to go, versus making something, from the condom stand, available to each and every prisoner who wants to pick up a few.

Is that possibility a way out of this dilemma, if you know?

DR. JENKINS: Well, when the issue of condoms came up, I discussed the issue of condoms with both Vermont and New York City. Their demographics are different. Their population is

just different from our population. The size of the facilities are different. For instance, I think Vermont had 600 incarcerees, we have 7,000. They have no -- or they have something like three or four sero-positives in their population. So the populations are really different.

That was one question I had -- in their state, they have laws which prohibit homosexual activities in the prisons also and I asked them, "How do you reconcile having laws on the books and being a correctional facility, whose purpose is to prepare people for the outside, and give them condoms? There would be no other reason for condoms other than sexual activity."

The only thing they could come up with is that it was the best medical judgment. I agree; it is the best medical judgment, but you have to keep in mind that there are other ways to prevent contacting this virus other than giving out condoms. I think the inmate population, and I have seen this reflected in their attitudes -- they have changed their behavior, because they know that there is a risk of contacting this disease by engaging in sexual activity, so there is behavioral change.

Whether or not giving out condoms -- you could ask the question, "Are they going to be used?" The other thing to

consider is that there are other ways to practice safe sex than using condoms, and we could go into the concept of frottage and other sexual practices which don't place them at high risk, other than penetration.

I think that is a point, I guess, that hinges around whether or not we give out condoms. But there are other ways to avoid getting AIDS and follow the laws that we have set down.

CHAIRMAN WASHINGTON: Dr. Cooke, do you have something?

DR. COOKE: I think we have been immeasurably aided today by the panel and the earlier panel, Mr. Chairman, and members of the Committee, in getting kind of a universal, broad picture of the AIDS question.

It has helped us, I think, to separate out that which is very significant, very grave in the whole AIDS picture and what is a responsibility of the Civil Rights commission, which is our responsibility; where we can determine that AIDS education is important, but not our direct responsibility; where we can determine that medical treatment, health prevention, other aspects of handling the AIDS question, can be identified, how important it is, but not our responsibility.

I think it will help us, in the long run, to be able

to focus on when is it that a person who suffers from AIDS is deprived of his rights or her rights. I think we have to, sooner or later, come to what is our responsibility as a SAC Committee of the United States Commission on Civil Rights. Not public health education, not any other education, but civil rights and the deprivation of rights.

CHAIRMAN WASHINGTON: Thank you, Paul. I think that brings to a good point of conclusion. We appreciated the panel here. The panel this morning was excellent; the panel this afternoon was excellent. You have brought forth some material and situations, circumstances that certainly will lead us and guide us as we approach the problem.

I am just delighted to be able to know that we will develop a transcript and have this available, not only for the members but for members of the public, I hope, as it is put together, collated and put together for distribution.

There were varying points of view here, varying approaches. I think the thing that stands out is that education and training, and education and training, and education and training appeared to be the great area for the solution of the problem, generally. Obviously, it has a medical base, as well. But in terms of approaching it and controlling it, the

educational feature seemed to come through from both panels as prevailing and as a point of view that must be disseminated throughout the entire community.

Again, I want to thank all of you. Members of the Commission will please stay for a few minutes. We have a couple of items, but I will try to get you out shortly.

Thank you very much, gentlemen and ladies that have come. We do appreciate your contributions.

(Whereupon, at 3:50 p.m., the above-entitled meeting was concluded.)